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OF
CUTANEOUS^(AND VENEREAL)
DISEASES *including Syphilis*

EDITED BY
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AND
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VOLUME III.

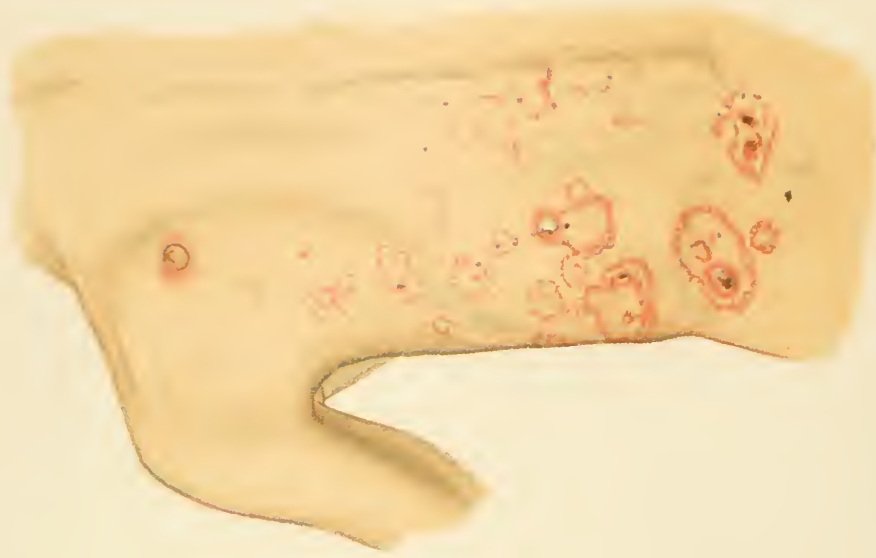
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No. 1.

Original Communications.

HYDROA; IMPETIGO HERPETIFORMIS; DERMATITIS HERPETIFORMIS.

BY

A. R. ROBINSON, M.D.,

Professor of Dermatology at the New York Polyclinic, etc.

AS the eruption which is represented in the accompanying illustration is a comparatively rare affection, and is at present the subject of considerable attention on the part of dermatologists, especially in America, I have considered it not inappropriate to publish a lithographic drawing of a well-marked case, together with a few remarks upon the subject. What the eruption should be called is still an undecided question, for though the name dermatitis herpetiformis, as given to it by Dr. Duhring, who has carefully studied the subject, has been accepted by the American Dermatological Association, yet it has not by any means been shown that the term hydroa, as first proposed by Bazin for certain eruptions resembling on the one hand herpes, and on the other pemphigus, is not in its proper acceptance sufficiently broad to include all these papular, vesicular, pustular, and bullous forms of eruptions which have been described under the terms impetigo herpetiformis, dermatitis herpetiformis, pemphigus hystericus, and herpes gestationis. After considerable study of the literature of the subject, and from my own observations on a number of cases which I have lately seen, I feel inclined to agree with the views of the late Dr. Tilbury Fox, as given in a most excellent article on hydroa in the *Archives of Dermatology* for 1880, wherein he distinguishes three varieties of the disease, viz., H.

simplex, H. herpetiforme, and H. bulleux s. pruriginosum. Further observation may enable us to separate these forms of eruption, or what is more likely, to include other forms produced by the same pathological agent or factor, as it is clear that the skin lesion is not a simple, local, idiopathic affair, but the result of some disturbance more general and deeper-seated, but whose nature we do not yet understand; consequently the skin lesion must vary in accordance with the intensity and duration of action of the producing agent, as well as from the ability of the skin to withstand the injury, and as a result, we may have a papular, vesicular, pustular, or bullous eruption, the arrangement of the lesions depending upon the nervous system and thus giving the herpetiform character generally observed. That the form of lesion present often depends upon the three factors above mentioned and not upon any difference in the producing agent, is shown by the disposition of one variety to pass into another, as well as by the multiformity of lesions present on the body at the same time. Until it has, therefore, been shown that the term *hydroa*, in the extended sense employed by Tilbury Fox, does not include the varieties described by Dr. Duhring and others, I do not feel justified in accepting the names lately proposed. To show how previous views required modification, it was formerly thought that that variety described by Hebra under the term *impetigo herpetiformis* was invariably fatal, whilst we now know that such is not the case; and further, that the *herpes gestationis* variety occurred only during pregnancy, when in fact it may be absent during pregnancy, to occur soon after parturition, as observed in one of my own cases in two successive attacks.

The subject is one which requires much further study before our ideas can be clear and definite in the matter. We owe much to the excellent papers lately published by Dr. Duhring, and hope other observers will follow in his footsteps.

History of case represented in plate. August 15th, boy, aged ten years, newsboy by occupation, medium size, and fairly nourished. The parents are healthy. Has one brother three years older, who has always been healthy. Three years ago he had an eruption which he says resembled the present one, and lasted several months. About ten months ago he had probably a mild attack of joint rheumatism. The present eruption was not preceded by any constitutional symptoms noticed by the patient, and commenced about two months ago, first on the ankles as clear bullæ, and later on the rest of the body. It is now abundantly present on the thorax, abdomen, lower and posterior part of scrotum, and especially on the whole of the inner surface of the thighs, and scanty on the legs and upper extremities. The soles of the feet and palms of the hands, as well as the mucous membrane of the mouth, are free.

The eruption commences as papules, vesicles, or bullæ, and forms at

present pin-head-sized to two inches or more in diameter irregularly-shaped patches. The pin-head-sized spots are red, elevated, inflammatory papules, which contain a little serum in their apex. The large patches consist of vesicles or bullæ, intact or ruptured, arranged in groups or rings and seated upon an inflamed and infiltrated base, or the patch has a more or less clear centre.

The collection of serum in the apex of the papules soon increases in quantity, and the papule becomes a well-marked vesicle seated upon a hardened inflamed base. The vesicle soon becomes flatter, at the same time it increases in size by peripheral extension. In many cases this extension at the periphery continued until the spot obtained a considerable size; at the same time the centre gradually returned to a normal condition, and producing appearances somewhat similar to those of ringworm of the body, except in the size of the vesicles at the spreading margin. On the back, most of the spots commenced as papules, and never became vesicles, but spread peripherally in exactly the same manner and with the same appearances as regards the lesion as occurs in ringworms, so that from these patches alone it would not have been possible to make a diagnosis without the aid of the microscope. Neighboring rings sometimes coalesced with resulting gyrate-formed patches. Sometimes a new lesion would form in the cleared centre of an older patch, usually a bullous lesion, which soon became opaque and dried to a crust, either with or without previous rupture. In many of these ringworm-like patches, close examination would detect small vesicles in the spreading margin, and there was less desquamation than is often observed in the parasitic disease. They sometimes attained a diameter of two or more inches, and the central part was either normal or contained a bulla, or dried crust, or was erythematous, and covered with slight scales.

Some spots commence as pea-sized or smaller bullæ, with walls and clear contents, situated upon an erythematous base and having a larger or smaller red areola. The bulla soon increases in size and becomes opaque, and new bullæ arise around it, giving the eruption an annular form. This arrangement of the secondary bullæ in an annular form around the primary bulla was a marked feature of the eruption on the anterior surface of the abdomen and thorax. Neighboring patches uniting, gave irregularly shaped, reddened, inflamed, and infiltrated areas covered with larger or smaller bullæ, or later presenting an excoriated surface with sero-purulent secretion and crusts from this secretion or from the contents of the bullæ.

The drawing should be studied by the aid of a magnifying glass, in order to properly observe the small vesicles at the periphery of the patches.

Sometimes around a central bulla the eruption spreads at the periphery as a raised, reddened, infiltrated area without the formation of

secondary bullæ, or the central bulla dries up, and new bullæ arranged in an annular form develop around it.

Two or more of these herpetic rings sometimes formed around this central bulla, or neighboring patches would coalesce to form the excoriated-looking patches already described, the whole patch resembling later eczema rubrum. This was especially the case on the inner surface of the thighs.

Isolated bullæ resembling a varicella or a pemphigus bulla, according to its size, were here and there observed, whose contents became opaque and dried up, without secondary bullæ forming. Bullæ sometimes as large as a walnut were observed and could not be distinguished from ordinary pemphigus bullæ.

The whole eruption was characterized by the grouping of the lesions, their arrangement in annular form or circles as in ringworm, in consisting of papules, vesicles, or bullæ, by intense itching and by marked pigmentation upon their disappearance. The pigmentation, of course, was due to the escape of hæmoglobin into the tissues in consequence of the scratching, more than from spontaneous hemorrhage, as very few bullæ contained blood.

Individual lesions lasted two to three weeks. He was given Fowler's solution, nine drops, three times a day; in a few days there was marked improvement, and in two weeks the eruption had entirely disappeared.

Nov. 28th.—Eruption has reappeared in the same form upon the inner side of the thigh and on the scrotum. I have excised a forming vesicle, and will report later the anatomy of the lesion.

PUERPERAL ERYTHEMA.

BY

J. CLARKE THOMAS, M.D.,

Obstetrician to the New York Infant Asylum.

IN puerperal septicæmia variable skin eruptions are met with. Of late considerable attention has been given them by dermatologists. The erythematous variety, the so-called scarlatiniform rash, has been termed the "Polymorphous or Multiform Erythema of Puerperal Infection" (J. Geneix, Th. de Paris, 1883).

Its etiological pathogenesis is the septic germ irritating the central nervous system, and causing vasomotor paralysis. It is frequently confounded with scarlatina in the puerperium.

Its diagnosis from scarlatina is often difficult. The absence of the history of the prodromata of scarlatina, and the absence of throat symp-

toms, the moderate temperature and the moderate amount of constitutional irritation, the history of the development and decline of the eruption, and the character of the desquamation are the differential points in the diagnosis. The following cases were met with at the New York Infant Asylum.

CASE I.—Mathilda Stroll, German, twenty-five years; primipara, labor normal, delivered October 22, 1883.

Day....	3		4		5		6		7		8		9		10	
	M	E	M	E	M	E	M	E	M	E	M	E	M	E	M	E
Temp...	102 $\frac{1}{2}$	99	100 $\frac{3}{4}$	99 $\frac{1}{2}$	101 $\frac{1}{2}$	101 $\frac{1}{2}$	Normal	Normal	Normal	Normal	100 $\frac{3}{4}$	101 $\frac{3}{4}$	100	103 $\frac{3}{4}$		
Pulse...	104	76	80	96	96	96	Normal	Normal	Normal	Normal	104	92	84	98		

An eruption of an erythematous character was first noticed in the evening of the *ninth* post-partum day on the neck, chest, and back (between the shoulders). It was bright red in color. It was diagnosed as a scarlatinoid eruption by the resident physician.

The general condition of the patient up to her ninth post-partum day was good; her convalescence appearing to be normal. Her lochia were natural in amount, odor, and color. Her appetite was good. October 30, her eighth post-partum day, she complained of "chilly sensations up and down her back," headache and moderate constitutional irritation nearly all day.

At 3 P.M. October 31, ninth post-partum day, she was seized with a hard chill that continued for fifteen minutes. In the morning of Nov. 1, the eruption had extended to the ankles. In the evening, the resident physician regarded the case as suspicious and isolated the patient in the "quarantine." Prof. J. Lewis Smith happening in the asylum late in the evening, was requested by the resident physician to see the case. He regarded it as doubtful, but was inclined to believe it to be a "septic rash." Nov. 2, Dr. H. G. Piffard was called to the case, and made a diagnosis of "puerperal erythema."

The eruption gradually faded and disappeared on Nov. 6. Desquamation began Nov. 3 on the neck and face; it was furfuraceous in character. On the chest it began Nov. 7, and was in large and irregular strips. Nov. 18. The desquamation is still in progress on the arms and legs. The appetite is good. Still in bed. Complains of nothing.

There is no history of specific or malarial infection. There was no throat trouble before or during her eruption. The only medicine given was gr. xx. bromide of sodium on the evening of Oct. 30.

After the eruption was diagnosed, sulphate of quinine, in gr. v. doses, was given.

CASE II.—Alice Wood, England, twenty-two years; primipara, delivered Nov. 11, 1883; labor normal.

Day...	1	2	3	4	5	6	7	8	9	10	11	12
Temp ..	M	M	M	M	M	M	M	M	M	M	M	M
	99	99 $\frac{2}{5}$	99 $\frac{2}{5}$	99	98.3	99.5	99.1	99.2	98.4	99	98.3	98.4
	E	E	E	E	E	E	E	E	E	E	E	E
	99 $\frac{1}{5}$	99 $\frac{2}{5}$	100	100.1	100.1	100.3	100.2	100.2	99.3	99.2	99	100.1
Pulse...	M	M	M	M	M	M	M					
	96	88	84	80	84	96	80					
	E	E	E	E	E	E						
	84	80	100	80	100	100						

Her convalescence was normal up to the evening of Nov. 16, her fifth post-partum day, when an erythematous eruption was detected on the upper portion of her chest and back. Nov. 17. The eruption was well-defined, bright red in color, and extended over the entire trunk of her body and on to her thighs.

She complained of a sensation of "pins and needles" over the surface of the body, and of chilliness, lasting nearly all day. No medicine had been administered with the exception of fld. ext. ergot immediately after her confinement. Nov. 18. The eruption had spread to her feet. The prickling sensation on the surface still continued. Her lochia were normal, as was also the mammary secretion. There were no throat symptoms. The case being regarded as suspicious, Dr. H. G. Piffard was called. He diagnosed puerperal erythema.

The desquamation was protracted, lasting seven weeks. It was irregular. It was repeated in the same localities. It appeared last on the back and chest. It was mostly in large scales. Her appetite was good.

She was isolated in the quarantine, as a mere matter of prudence.

In these two cases the eruption

(a) Resembled that of scarlatina.

(b) It extended slowly from the upper portion of the body to the lower extremities.

(c) There were no throat symptoms.

(d) There was but little constitutional irritation, as measured by fever and depression of vitality.

(e) The desquamation was irregular as to character, duration, and recurrence.

(f) The possibility of their origin being from drugs was readily excluded.

In examining the asylum records, we have found the following history of a somewhat similar case:

Maggie Jones, twenty-five years, Wales, primipara, healthy. Family history good. She was confined at the asylum, October 18th, 1882. Labor was normal. Infant was a female.

TEMPERATURE.

Day..	1	2	3	4	5	6	7	8	9	10	11
	M	M	M	M	M	M	M	M	M	M	M
	99	99 $\frac{2}{5}$	100 $\frac{2}{5}$	102 $\frac{2}{5}$	100 $\frac{2}{5}$	100	100 $\frac{2}{5}$	99	99 $\frac{1}{5}$	99 $\frac{2}{5}$	99
	E	E	E	E	E	E	E	E	E	E	E
	101 $\frac{1}{5}$	102 $\frac{2}{5}$	103 $\frac{1}{5}$	104	103	102	100 $\frac{1}{5}$	100 $\frac{1}{5}$	99 $\frac{2}{5}$	100 $\frac{1}{5}$	100 $\frac{2}{5}$

PULSE.

1	2	3	4	5	6	7	8	9	10	11
M	M	M	M	M	M	M	M	M	M	M
E	E	E	E	E	E	E	E	E	E	E
90	96	132	92	96	88	84	84	88	84	84

On the morning of the *second day after delivery*, a bright red and slightly elevated, discrete eruption appeared on the *lower extremities* and gradually, during the day, extended up the back and on to the chest. In the evening the eruption had become confluent upon the lower extremities, and resembled that of scarlatina. There were no throat symptoms. The fever was moderate.

On the third day the eruption became diffuse on the back, chest, and upper extremities. On the back it was somewhat elevated, in wheals.

On the fourth day the eruption began to fade, and on the eighth day had entirely disappeared.

No desquamation followed. Lochia were normal. Mammary secretion was normal.

The patient did not complain of anything except a sensation of intense irritation of those portions of the surface invaded by the eruption.

PELIOSIS RHEUMATICA.

BY

ETIENNE C. VIDAL, M.D.,

New York.

JUNE 12, I was consulted by H. B., male, twenty-five years old, native of Germany, for an eruption situated on the lower extremities, accompanied by œdema of the ankles, and a "sticking, cutting, pain" in these articulations. The right ankle was considerably swollen and covered with a confluent efflorescence of a purple hue. Above this latter, and extending to the knee, were smaller patches varying in size from that of a ten-cent piece to that of a silver dollar. In addition to these were maculæ, round in form, and the size of a lentil. Their color, a brighter red than the above-described efflorescence, persisted under finger pressure. On the left ankle, the color of the eruption was brighter than that of the right. It assumed sharply defined forms, leaving the anterior aspect of the articulation entirely free. The inferior portion of the left leg as high as the knee was covered with an eruption similar to that on the right. There was less pain and œdema in the left ankle. The dorsal surface and the sides of both feet presented the same variety of maculæ; they likewise existed on the back of the hands. A few very

indistinct spots of a pale-yellow color offered on the palms of the hands. The patient suffered from fever and headache; he had no appetite, was weak, and presented a general anæmic condition. Walking was exceedingly painful and increased the swelling.

The patient informed me that, three evenings before his visit to me, he had been out drinking. The following morning, he experienced pain in the ankles, and found that they were swollen. During the day the spots appeared on the legs, and in the evening fever set in. The second day the spots were seen on the hands and feet. When I saw him at the consultation, on the third day, the efflorescence had partially disappeared, there was less œdema, he had no fever, no headache, appetite good, but the urine was colored. On the third day after I saw him, the eruption disappeared; the swelling, a day later. There was no relapse, the disease having run a course of ten to eleven days.

The horizontal position, tinct. ferri chlor., and cold-water dressings constituted the treatment.

CONGENITAL CONTRACTION OF THE MEATUS URINARIUS.

BY

MAHLON HUTCHINSON, M.D.,
Chicago, Ill.

I DESIRE to report the following cases for the reason that I have seen so many examples of contraction of the meatus urinarius, giving rise to reflex troubles, and occurring in patients treated by various physicians and surgeons who did not deem it necessary to operate, but contented themselves merely with giving internal medicines.

CASE I.—Mr. C. C. C., aged twenty-eight, married, consulted me on November 22, 1882, for a presumed organic urethral stricture. He had been subject to sudden attacks, occurring every six weeks or two months, for the past six years, of inability to urinate. Eight years before, he had contracted a gonorrhœa, which lasted about two months, and was cured with but little difficulty. He, of course, referred his subsequent attacks to that gonorrhœa, and had been confirmed in his belief by consultation with six surgeons, two in Buffalo, N. Y., two in New York City, and two (prominent) ones in Chicago. They all agreed in a diagnosis of organic stricture, and advised strongly an operation. Four of them had passed catheters during his several attacks, and, with great difficulty and considerable pain and the drawing of some blood, had succeeded in reaching the bladder and relieving him for the time being. The patient was a large man, weighing over two hundred, of full habit, and of very passionate nature. He informed that, during his married life of six years, he

had probably had connection with his wife once a day on an average. Upon examination of patient's genital organs, I found a small penis, very much retracted, with a meatus the size of a pin's head, reddened and inflamed. Upon attempting to introduce a sound, I found the urethra so irritable that Mr. C. was unable to stand the pain. I decided that the first, and probably the last, thing to do was to slit the meatus. I scarcely thought there could be any organic stricture, for between the attacks of the complete stoppage of urine the flow was as full and as free as if from a perfectly healthy urethra. Telling Mr. C. what I desired to do, he strongly objected, dreading, above all things, the use of the knife. He was brought to terms, however, by another threatening attack, and coming to my office on December 5th, 1882, the simple operation was quickly performed, and the patient dismissed. The after-treatment was the introducing of a pellet of cotton to keep the cut surfaces apart, and, without the administration of a single dose of medicine, Mr. C. has remained well, never having had an attack since the day he was operated on.

CASE II.—Mr. Geo. S. was first seen by me on February 20, 1882. He complained of inability, at times, to hold his water, frequent micturition, and sudden and imperative calls to urinate. Upon examination, I found a meatus quite small and divided in two parts, forming two openings, by a tissue band. I immediately divided this band and enlarged meatus by an eighth-of-an-inch cut, and prescribed an alkaline mixture, the basis being potassæ citrat. Patient seen three months thereafter; had had no return of his previous symptoms.

CASE III.—Mr. M. A., age nineteen, single, an upholsterer by trade, was first seen by me on October 6, 1884, and is at present under treatment. Patient's history was that he masturbated from the age of fifteen to seventeen; that he then gave up the habit, and began to relieve himself by indulging in intercourse regularly every five or six weeks; that, up to six months ago, everything was natural and right, but that one night he suddenly found himself impotent, unable to command an erection; and that, although his attempts have been frequent, he still remains in the same unfortunate condition. Nocturnal emissions, without dreams, have occurred twice a week for past three months. Upon examination, I found a shrivelled penis, and meatus no larger than that described in case I. I immediately slit it. Treatment since has consisted in the passing of the cold sound and the administration of bromides and Fl. Extr. Gelsemii (Gross), to reduce the very irritable condition in which I found the prostatic urethra. Mr. A. feels very much encouraged over the rapid improvement obtained in the condition of his genitals, as regards irritation and the cessation of the nocturnal emissions, and is as confident as I that it is only a question now of a little time until his sexual strength is fully restored.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

149TH REGULAR MEETING.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. KEYES presented a case of

PERSISTENT SYPHILITIC ROSEOLA.

James —, two and a half years old, has albuminuria, parenchymatous nephritis, cedema, and bronchitis. He has a general eruption of syphilitic roseola, which made its appearance four weeks ago and has remained ever since. On the right side of the anus the primary lesion can still be seen. The mother and father are perfectly healthy. The mother has never had any miscarriages.

DR. FOX exhibited a case of

SYPHILIS MODIFIED BY ECZEMA.

A woman about fifty years old. Has had the present eruption off and on for the past five years, and during that time has been subject to attacks of rheumatism. Now she has an eruption with a rather well-marked margin, extending on both the radial and ulnar side of the left forearm to near the middle, where the two portions of eruption form a band about two inches broad across the posterior aspect. The lesion is also found on the ulnar side of the hand, also on the knuckles, as well as on the back of the middle, ring, and little fingers. At the bifurcation of the fingers the skin is healthy. A patch of eruption is also to be seen on the ulnar side of the right hand, above the little finger. No eruption on the palms, or elsewhere on the body. The treatment has been acetate of potassa internally, and ointment of oxide of zinc externally, without much benefit.

DR. JACKSON said that when he first saw the case, some time ago, he believed it to be psoriasis, there being nothing in the appearance of the lesion to suggest syphilis, except the raised border.

DR. MORROW believed the case to be one of eczema, pure and simple, and he did not think that there were any modifying effects of syphilis present.

DR. SHERWELL was abundantly well satisfied that eczema and syphilis can occur in the same person and at the same time; he, however, believed this lesion to be an eczema.

DR. KEYES said that he did not see anything in the appearance of the eruption that would lead him to believe that it was influenced by syphilis.

DR. STURGIS did not think that the external appearances showed that the eruption was modified by syphilis.

DR. ROBINSON said that he had seen many cases similar to this, modified by a rheumatic diathesis; he would regard this lesion as one of eczema of a chronic form. He did not think that syphilis would modify the form of an eczema, but that it would influence the course of the eruption.

DR. FOX said that he had believed and taught that syphilis does not modify the course of an eruption. He mentioned the case of a man whom he had hoped to present to the Society, and who had in some places orbicular patches of eruption tending to heal in the centre, in others there would be a healthy isthmus of skin between two diseased patches. In the case under consideration, the peculiar raised margin of the eruption, and the tendency to heal in the centre led him to suspect a syphilitic taint. He believed that the basis of the eruption was

syphilis, and that when the patient was put on anti-syphilitic treatment there would be an improvement, and final disappearance of the eruption.

DR. SHERWELL showed a case of

PEMPHIGUS CACHECTICORUM.

Bessie W., three and a half years old, has had the present eruption ever since January last. The lesion first made its appearance on the chin and around the lips as small bullæ. The mother says that when the eruption first appeared it looked as if the child had been scalded.

Now on the cheeks and chin is an eruption of broken-down bullæ, also similar lesions on the neck above the notch of the sternum, on the forearms, the inner side of both thighs, and in the popliteal spaces. On the buttocks, especially the left side, is a scattered, discrete eruption, greatly resembling scabies. No other members of the family have an eruption. The child appears to be in good health.

DR. FOX regarded the case as one of the commoner forms of dermatitis herpetiformis.

DR. STURGIS asked if you could get such enormous bullæ in dermatitis herpetiformis as were seen in this case; in all the cases he had seen the bullæ were not so large.

DR. ROBINSON believed the case to be one of dermatitis herpetiformis, the pustular form described by Hebra, because of the multiform character of the eruption. This case corresponded in many particulars with that lesion, the inflamed base to the eruption, the grouping, its itchy nature, the pigmentation, chronic course, and situation on the inner side of the thighs. He had had a well-marked case in which the eruption existed on the inner side of the thighs.

DR. SHERWELL said that he considered the lesion to be a pemphigus, necrogenic in character. During the French war he had seen similar cases occurring in persons where there was a tendency to pyæmia.

DR. KEYES then presented a

CASE FOR DIAGNOSIS.

Mary H., nine years old. The mother says that the child had brain fever four years ago; a year after, or three years ago in May, a bullar eruption made its appearance on the palms and soles, with papules on the back of the hands and arms, containing pus and itching greatly. It came in crops and lasted all summer, with intermissions of several weeks. Each new attack was announced by an outbreak of fever for twenty-four hours. Each October the eruption disappears and again appears each May. This year the eruption is worse than usual, some papules appearing on the neck. The general health is good. Soda relieves the itching.

DR. FOX showed a case of

RECURRING BULLOUS ERUPTION.

A well-developed child, two and one-half years old, has had a recurring eruption for the past two years. The lesion makes its appearance as vesico-pustules, the base then spreads and large bullæ form, which when they dry down leave scars with pigmented edges. The eruption is scattered mainly over the thighs and legs. The child was vaccinated when four months old. No history of eruption in the family.

DR. FOX afterward presented a

CASE FOR DIAGNOSIS.

A single woman, twenty-five years of age, has been troubled for many years

by outbreaks of eruption around the elbows and ankles, and recurring every two or three weeks. The eruption makes its appearance as vesicles in groups; soon after there is a hemorrhagic effusion into the vesicles, then they break down into ulcers with ragged edges. The ulcers are accompanied by considerable pain. There is slight itching of the affected parts. The general health is good, with the exception of increased frequency of menstruation.

DR. MORROW showed a case of

DISEASE OF THE NAILS.

Alphonse D., French, forty-four years old. Cook. There is no history of syphilis. The disease first began to develop three years ago upon the forehead at the margin of the hairy scalp. The patient first noticed a small itchy spot which gradually spread, soon attaining its present dimensions. Six months later, the disease appeared upon the outer aspect of the legs, midway between the knee and the ankle. Two years ago it commenced to develop upon the penis, and now involves the entire penis, scrotum, perinæum, and anal region. It also extends along the inner surface of the thighs and over the pubic region. The disease has within the last six months become generalized. There are scaly patches in the axillæ, in the popliteal spaces, with scattered patches upon the back, cheek, forearms, hands, and legs.

The nails began to be affected about eighteen months ago. The lesion commenced first upon the thumb and great toe nails, and afterwards extended to all the nails.

The patient states that the disease first attacks the base or side of the nail, and gradually affects the entire nail substance. All of the nails have been lost and some of them partially replaced by new nail growth.

It will be seen that the nail beds of most of the fingers are occupied by a thick, rough, uneven and friable substance of horny consistence which is easily detached and separated. Sometimes the nail gradually exfoliates, at other times it is detached *en masse*. The posterior and lateral cutaneous folds are unaffected, as in ordinary cases of eczema unguium.

DR. KEYES presented a case of

SYPHILITIC GUMMATA.

A boy, eighteen years old, has always had good health. Never had venereal disease, no keratitis, and no notching of the teeth. There is no history of syphilis in the family. Two years ago one of the patients' testicles was removed by Dr. Lange, on account of suppurative disease of that organ. Two months ago a large lump appeared on the left side of the forehead, which gradually increased in size until placed under treatment two weeks ago. There is also a smaller gumma situated beneath the left eye, and over the malar bone.

Two weeks ago, the gumma on the left side of the forehead was somewhat over three inches in diameter, that on the cheek being considerably smaller. Dr. Keyes recognizing the case as a late hereditary syphilide of a gummatous form, placed him on the mixed treatment. Since that time the lumps have been shelving at their base, and gradually growing smaller in size.

DR. BULKLEY exhibited a case of

PSORIASIS OF THE PALMS, ETC.

Elizabeth R., sixty-eight years old, widow, English, has had the present disease for thirty-five years. It first made its appearance on the dorsum of the

hands, in spots which gradually coalesced, forming patches that completely covered the hands. The patches were of a coppery color, covered with white scales of a bright glistening appearance. Four years afterward it appeared as scattered spots on the legs, arms and trunk, the lesions varying in size from that of a split pea to patches three or four inches in diameter.

When first seen by me, the whole body, with the exception of the face, was covered with coppery patches, having elevated and well-defined borders; these patches were deeply infiltrated and covered with thick white glistening scales, which on being removed left a purplish red base. On the extensor surfaces of the legs were excoriated patches, ranging from one to three inches in diameter, weeping, burning, and itching. The back of the hands, especially over the knuckles, were deeply fissured. The disease appeared on the palmar surfaces as small, millet-sized spots, covered with a thin scale leaving a smooth base on removal. The lesion also presented itself as hard, thick, fissured patches on the plantar surfaces of both feet. The legs were quite oedematous. She remained under my observation at the hospital for seven weeks, and was then discharged, being entirely free from eruption. The treatment was local only, chrysarobin pigment being employed.

The disease reappeared three weeks after leaving the hospital, first on the dorsum of the hands, and gradually spread until it again involved the arms, legs, thighs, lumbar and scapular regions. It also appeared on the dorsal and plantar surfaces of the feet. At present the legs are covered with thick, hard scales, especially over the anterior aspect. The patient is now being treated locally with chrysarobin, and internally is taking equal parts of mist. rhei et sodæ, and potas. acetat., twenty-five-per-cent solution.

DR. FOX then presented a case of

RECURRENT EXFOLIATIVE ERYTHEMA.

A woman, twenty years old, unmarried, Swedish, was first seen by Dr. Fox one week ago, when the hands presented an appearance resembling an ichthyosis, being very stiff, hard, and thickened. Even three days ago the eruption was well marked. The diseased skin could be very readily divided into several layers. Now the left hand is very greatly thickened and the hardened diseased skin is still seen to be made up of several layers. The right hand is much softer. She has had previous attacks of a like character, the lesion commencing as an erythema, followed by thickening of the skin, and finally ending in desquamation. A similar case has been described and illustrated in "Photographic Illustrations of Skin Diseases, Part II."

The Secretary then read the following on behalf of DR. PIFFARD:

CASE OF RECURRENT DERMATITIS EXFOLIATIVA.

I yesterday saw in consultation with Dr. Denhard a young man, seventeen years of age, who gave the following history: During the last twelve years he has had nine attacks of dermatitis exfoliativa. The attacks are ushered in by febrile symptoms, followed by the appearance of a scarlatinoid rash which after a few days gives rise to extensive exfoliations. The entire attack occupies about two weeks, and the patient's health in the intervals is good. I accompany this with specimens of casts of the palms and soles.

DR. KEYES afterward read the following paper, entitled:

NOTE ON HYDROCHLORATE OF COCAINE—ITS POSSIBLE DERMATOLOGICAL USES.

During the past two weeks I have employed the hydrochlorate of cocaine in

four-per-cent watery solution a great number of times, and with such manifest advantage to myself and satisfaction to my patients, that I think a word upon the subject may be not unacceptable to the Society. The surface sensitiveness of the anterior urethra may be so deadened by injecting ten minims of this solution along the pendulous and into the prostatic urethra by means of a deep urethral syringe that manipulation by instruments is tolerated much better than where this agent has not been used. No appreciable effect is produced on the deep urethra, and only the surface sensitiveness seems to be blunted. Cutting or stretching strictures is still painful and irritability at the neck of the bladder not sensibly modified, yet a manifest advantage is obtained in the facility with which explorations may be made and cutting instruments inserted before the painful final incision is made. Meatotomy may be performed almost without pain in some cases, and in one instance I performed deep internal urethrotomy to the great delight of the patient, who had been cut in former years. He joined in applauding the new method.

Chancres and warts, I judge, may be rendered insensitive to caustic, although I have not yet personally proved the fact.

Small tumors may, however, be cut out from the skin, and subcutaneous tumors removed almost without pain.

My first case was that of a physician with a small syphilitic chancre on the dorsum of the penis. The lesion was less than two days old, but the party from whom it had been acquired had undoubted syphilis. No glands were involved and the doctor wished the sore to be removed. I injected four minims of the solution directly under the sore, washed the whole cutaneous surface in a two-and-one-half-per-cent bichloride of mercury solution, picked up the sore and a fair amount of surrounding integument with toothed forceps, and with one cut of a scissors curved on the flat removed the sore, and the entire thickness of the skin beneath and around it. I then arrested hemorrhage, tied a small vessel, and applied three points of catgut suture. The doctor looked on smiling, and declared that although he could feel pressure he experienced not the slightest pain during all the manipulations.

My next case was the removal of a small epithelioma from the margin of the anus. I injected ten minims of the solution, five on each side of the ulcer, stretched the sphincter to a circumference of six inches with a three-bladed dilating speculum, and removed the growth. The stretching caused considerable pain, the cutting little or none, according to the patient's statement.

I have also removed warts, moles, and lipoma from physicians and patients with a uniform testimony that the pain was not worth mentioning. I have relieved mild anal pruritus at once by the application of the six-per-cent oleate, although the effect was quite temporary. The possible advantages of this application endermically or hypodermically need only be alluded to be appreciated.

What could be more agreeable, should it prove effective, as I believe it will, than to inject ten or more minims between the folds of the prepuce, and then cut away the prepuce and its injected fluid, and apply the sutures after circumcision without pain?

In cutting out lipomata, fibromata, wens, warts, and the like; in scraping, cauterizing, electrolyzing the skin; in tenotomy; possibly in removing inflamed glands and opening abscesses, in epilation and many similar processes it seems to me possible that a great future is open to this remedy.

What it will do when injected subcutaneously for superficial neuralgia and intense pruritus (scrotal for example) I have yet to learn.

No evil effects, local or general, follow the injection. A feeling of mild pleasurable excitement is experienced temporarily by some patients.

In the discussion which followed, Dr. Jackson narrated the case of a woman who came to him to have epilation performed, whose skin was so sensitive, when he began treatment on the 22d inst., that the slightest touch, when nine cells were used, would cause intense pain. He then applied a four-per-cent solution of muriate of cocaine in oleic acid over the left side of the lip and chin, and when the needle was inserted, there was only a little smarting of the part. To test the efficacy of the application, the needle was inserted on the right side, where the cocaine had not been applied, and intense pain followed.

DR. MORROW said that he had not had much experience in the use of the drug. He had used a four-per-cent solution on his own person, and so far as the abolition of sensibility was concerned, there was no marked effect. He had used the drug with marked benefit in cases of acute coryza. At the last meeting of the Medical and Surgical Society, Dr. Agnew was very explicit in his statements, and it was the universal opinion that in order to have any marked benefit result, it was necessary that the fluid should reach the papillæ. Dr. Morrow thought that in the form of the oleate, the cocaine would have a greater penetrating effect.

DR. SHERWELL had no personal experience in the use of the drug. There was a series of cases which Dr. Keyes had not mentioned, where he thought it would be useful; he referred to the operation for cure of painful fissures of the rectum: in such cases, he believed that pencilling with a solution of muriate of cocaine would lessen the sensibility during the operation of stretching or cutting the parts.

DR. STURGIS said that he had used a two-per-cent solution of American muriate of cocaine in passing sounds, but was not satisfied that it did any good. He injected twenty minims of the solution in the anterior portion of the canal. He thought that the subcutaneous injection would be attended with more certain results.

DR. KEYES, in concluding, said that thus far he had found that only the surface sensibility was modified. In cases of sensitive urethras he had passed sounds without pain, having previously applied the drug. In stricture, the passing of the instrument was not felt, but when the stricture was about to be stretched there was pain. Dr. Taylor had informed him that he had applied the muriate of cocaine to the prepuce, and had performed circumcision without pain. He had used the drug on some of the students in his class with the effect of diminishing the cutaneous sensibility.

Selections.

SYPHILITIC AFFECTIONS OF THE JOINTS, TENDONS, TENDON-SHEATHS, AND BURSAE MUCOSÆ.

THE fact that lesions of the joints may be occasioned by syphilis has been recognized ever since this disease began to be accurately studied, *i. e.*, from the latter half of the fifteenth century. Observers in general, commencing with Peter Martyr, in 1488, and ending with Louvrier, in 1809, seem to have entertained no doubt upon the subject. Yet it is remarkable that the great authority of Hunter was directly opposed to the prevailing view. He says: "I do not recollect ever to have observed an instance in which syphilis has affected the joints, although many rheumatic disorders of those parts, which were cured by mercury, have, on this account, been regarded as venereal." Babington, Hunter's pupil and the editor of his works, commenting upon this passage, remarks that the judgment it embodies is too unqualified, and many succeeding writers have concurred in this opinion. A few, however, and those of

no mean repute, have contended that, although disorders of the joints do unquestionably arise during the course of specific disease, they may be referred to other causes than the syphilitic diathesis. Thus Colles (1839) attributes them to the mercurial cachexia, while by Ricord (1848) they were connected with rachitis, scrofula, and gout. For the earliest accurate account of syphilitic diseases of the joints we are indebted to Richet (1853), who, with other French investigators of our subject, opened up the path, in which they have since been followed by the Germans.

Taylor, of New York (1871) describes the chronic inflammatory and gummy affections of the finger joints, their tendons, and the sheaths of the latter, as accompaniments of dactylitis syphilitica, and cites two cases of tertiary synovitis. E. L. Keyes (1876) was the first to give a detailed account of syphilitic disorders of the bursæ mucosæ, dividing them into tertiary and secondary forms.

Among the latest writers, H. and M. Zeissl, in their "Lehrbuch d. Syphilis," 1882, speak with much reservation concerning specific lesions of the joints, and incline strongly towards Ricord's doctrine as above-mentioned. Krowczynski (1883), on the other hand, coincides with the French authorities, who regard the arthralgia, the subacute arthritis, and the hydrarthrosis, as forms of syphilitic joint disease. The rare occurrence of gummata around the joints he explains as due to the slight vascularity and the rigidity of those parts.

The *pathological anatomy* of the disorders we are considering has never yet been fully explored. The first recorded autopsy on a syphilitic subject in whom they existed was made by Coulson in 1858. Méricamp, in 1882, published an interesting case which may serve as a sample of the whole number: A woman in whom the initial symptoms of syphilis appeared in 1856, suffered, in 1859, from a swelling of the elbow, which, after returning several times, yielded at last to the action of the potassic iodide. In 1874, swellings appeared on the left knee and left elbow, caused by exostoses; also many similar growths on various bony parts. After her death, in February, 1882, the following changes were found to have taken place: Excepting some superficial erosions of the cartilage, the constituent portions of the joint were intact; the shaft of the femur was doubled in size by stalactitic exostoses; beneath the articular cartilage was a gelatinous deposit of a gold-yellow color, whose gummy nature was clearly revealed by the microscope. The left elbow joint was similarly affected.

Post-mortem examinations have taught us but little concerning syphilitic disorders of the tendons, and nothing whatever as to those of the bursæ mucosæ.

ETIOLOGY.—Under this head, in view of the fact that so little is known respecting syphilitic disorders of the joints, and that their very existence has been denied by prominent authorities, the following question claims our first consideration, viz., *Can simple uncomplicated syphilis, without the co-operation of other causes, suffice for the production of articular lesions?* Our answer is decidedly in the affirmative, for reasons which we now proceed to detail.

It has been shown by Virchow that syphilitic affections must be divided into two distinct classes. The first of these comprehends those merely inflammatory processes which run a more or less rapid course, and exhibit nothing of a specific nature either in their symptoms or in their underlying pathological conditions, while under the second are included all forms properly termed specific as being dependent in their origin and development upon that morbid project peculiar to constitutional syphilis, the gumma. We can only be positively certain, therefore, that an individual organ or organic system is affected with syphilis when we

know that it has suffered those gummy alterations which are characteristic of that disease, and the same test must be applied in order to determine the syphilitic nature of any merely inflammatory changes which it may have undergone. The correctness of this position has been demonstrated by post-mortem examinations. But it would also be a very extraordinary circumstance for any constitutional disease, more especially for one of an infectious nature, *not* to attack the joints, as may be inferred from the complications which so often arise in the course of measles, scarlatina, variola, typhus, cerebro-spinal meningitis, dysentery, dengue, and glanders. Moreover, the history of a syphilitic joint-affection is distinguished from that of other articular diseases by many striking peculiarities. Thus, if we examine closely, we shall find, perhaps, in a case which at first might be taken for one of ordinary polyarticular rheumatism, that the bodily temperature rises and falls with singular abruptness; that there is a total absence of cardiac complications; that the affection remains seated in a single joint, and displays a tendency to linger; that it passes into chronic forms, and that the pain is comparatively trifling in day time, but greatly aggravated in the evening and at night. All of these characteristics are strongly marked in many cases of syphilitic joint-disease, which they serve to distinguish from other non-specific forms of acute and chronic arthritis. If, in a patient presenting these signs, we can detect the manifestations, whether late or early, of a syphilitic diathesis, we shall be fully justified in referring his arthritic complaints to a specific origin, especially when, in addition, we are able to exclude (or, at least, are unable to discern) the operation of other causes. One important indication still remains to be mentioned. When confronted by an otherwise inscrutable ailment, we are wont to draw conclusions respecting its etiology from the results of treatment, and particularly as regards those widely-differing forms which may be attributed to syphilis must this last procedure oftentimes constitute our last resort. Nor can it rightly be called an unsafe one. It is a well-known peculiarity of syphilitic diseases in general that they show little or no tendency to disappear spontaneously, or in consequence of a merely symptomatic treatment, while, on the other hand, specific medication, as a rule, is speedily and remarkably successful. This observation applies with equal force to disorders of the joints. Just as we unhesitatingly pronounce a paralysis of the motor oculi, an iritis or a choroiditis, a periostitis, etc., when occurring in a syphilitic subject, to be a symptom of syphilis, if, after defying other remedies, it yields to anti-syphilitic agents, even so must we judge, under like circumstances, in the case of an arthritis. Finally, the fact, established by post-mortem examinations, that articular lesions may accompany hereditary syphilis, supplies further evidence in favor of our proposition that they may likewise proceed from the acquired infection.

But little attention has been paid to syphilitic disorders of the tendons, tendon-sheaths, and bursæ mucosæ. The fact of their occurrence, however, is beyond dispute.

COURSE AND VARIETIES.—Syphilitic affections of the joints are much more common than is generally supposed. Only a portion of them lead to alterations in growth and nutrition; the remainder take on the form of functional disturbances, viz.:

I. Arthralgia.—Pains in the joints are a frequent concomitant of constitutional syphilis. They make their entry at a very early stage, often forming one of the most prominent symptoms of the eruptive period, and subsequently preceding and accompanying every fresh outbreak of the disease, without ceasing their attacks, even during the intervals of complete remission in other respects.

They usually affect only the large articulations—those of the knee, hip, and shoulder, though occasionally felt in the finger joints. Sometimes they are described as of a boring or rending character, and are especially aggravated at night, causing little trouble during day-time: in other cases, a sort of stiffness in the joints is complained of, chiefly on moving them after resting a good while. Thus, on first rising in the morning, the patient can scarcely get about, owing to pain which seems caused by the ends of the joints rubbing against each other, “as if all the oil were out of them.” As movement proceeds, it becomes less irksome, and during the rest of the day the pain is experienced only after repose, or else ceases altogether, to return with renewed intensity on the following morning. In many cases of this sort, friction and crepitation of the joint are objectively apparent, leading to the conclusion that the ailment is not simply neurotic, but is due in part to slight exudative processes.

Of more serious import than these purely functional disturbance are those articular affections which depend upon altered states of nutrition, and are capable of pathological demonstration. Following Virchow's classification, we will divide them into simple, exudative, irritative, and specific gummy varieties.

II. *Simple Inflammations of the Joints*.—These run their course under the guise of acute and chronic serous synovitis. The latter are divided, according as the synovial affection is primary or consecutive, into a *protopathic* and a *deutero-pathic* variety, each of which includes several subordinate forms.

1. Among *protopathic synovitis* we enumerate:

(a) *Acute Polyarticular Synovitis*.—This bears a strong resemblance to polyarticular rheumatism. It is marked by a very painful swelling, usually of the larger joints, several of which are attacked simultaneously or in quick succession, and is attended with considerable fever. It is distinguished from acute rheumatism by its strikingly remittent fever curve, but still more by the fact that salicylic acid, which is the specific against polyarticular rheumatism, exerts no influence upon this syphilitic inflammation. Acute polyarticular synovitis, on the other hand, is promptly subdued by the specific action of potassic iodide. When this latter complaint is unseasonably or injudiciously managed, it shows little tendency to subside; in this case, as a rule, the symptoms merely become less acute, pain and fever diminishing, while the changes characteristic of chronic hypertrophic synovitis are developed in the joint.

(b) *Acute Monoarticular Synovitis*.—Rapid swelling of a single large joint, to which it is confined throughout the duration of the complaint, attended with inflammatory symptoms, and generally moderate fever. Here, also, salicylic acid is without effect, while potassic iodide very soon removes the trouble. Under improper treatment the inflammation subsides, but the swelling remains, and this form, like the preceding, passes into

(c) *Chronic Hypertrophic Synovitis; Hydrarthrosis*.—This makes its appearance, sometimes as an outcome of (a) or (b), sometimes as a primary affection, in the shape of a painless swelling of the joint, which gradually advances, unless opposed by antisymphilitic remedies. The pathologico-anatomical changes which it occasions have been clearly shown to consist in chronic hyperplastic inflammations of the capsule, with proliferation and the production of villi; erosion and destruction of the cartilage, causing deformity of the articular extremities; and, finally, in ankylosis.

2. All these analogous varieties of synovitis are also developed *deutero-pathically*, by the extension of syphilitic disease from neighboring parts, most frequently the bones. In this case, also, we distinguish two forms, the acute and

the chronic, which depend respectively upon the acute or chronic nature of the primary affection.

An opinion which has recently been advocated by some prominent authorities, *i. e.*, that in *hereditary syphilis only the shafts of the bones are invaded*, in *acquired syphilis only their epiphyses*, I must pronounce to be untenable, whether clinically or anatomically regarded.

III. *Gummy Arthritides*.—In this variety the gummata are not known to be developed primarily from the synovial membrane or the capsule, and afterwards to fill up the cavity of the joints by their proliferations. They form, in the first place, upon and around the articular ligaments, and in the loose cellular and adipose tissues enveloping the capsule, and are accompanied by chronic synovitis and serous effusion into the cavity of the joint, and proliferation of the synovial membrane; the gummy process invading the capsule and penetrating into the interior of the joint only at a later period. All these processes take place chronically; the symptoms varying in their development and combinations, according as the gummy formation or the serous synovitis takes the leading part. Thus, in the former case, we may have a chronic pannous arthritis, with production of nodes which can be felt within the capsule, or outside of it in one or the other articular ligament, while, in the latter, there occurs a painless, tense, generally uneven swelling of the joint, the contents of whose cavity are only slightly increased. The breaking through of the gumma, inwardly and outwardly, may lead to pyarthros, by laying open the articular cavity.

IV. *Anchylrosis*.—The chronic hyperplastic and the gummy arthritis have this in common, that both are accompanied by a new formation of connective tissue. In this way the capsule and the articular ligaments are thickened, and new connective-tissue cords are formed, which extend from one extremity of the joint to the other. As time proceeds, these cords retract and become more and more rigid, until motion of the part is impeded, or rendered completely impossible, by the establishment of a fibrous anchylosis. Bony anchylosis, to a greater or less degree, may arise, in cases of periostitis, from osteophytes on the epiphyses, with deformity of the articular extremities: or, finally, ulcers of the joint may result in cicatricial contractions leading to anchylosis spuria.

Among the articulations, that of the knee is by far the most frequent seat of syphilis; next in order come the elbow, shoulder, and hip-joints, while the wrist is very rarely affected.

Syphilis of the Tendons and Tendon-sheaths undoubtedly occurs; and here also we distinguish two forms, the irritative and the gummy.

1. *The irritative form* may show itself as:

(a) *Tendovaginitis*, in which increased effusion into the sheaths of the tendons is followed by tense and painful red swellings along the course of the latter, together with febrile symptoms. Motion is impeded and often quite impossible; it is frequently accompanied by friction, which is caused by the mutual contact of coagula adhering to the tendons and their sheaths, and is apparent to both touch and hearing. In other cases, the complaint is chronic, and takes the form of

(b) *Dropsy of the Tendon-sheaths*.—A cylindrical or spindle-shaped swelling following the course of the tendons. It is quite painless, is covered with normal skin, fluctuating, and often crepitates plainly on palpation.

The former of these processes terminates in recovery, or becomes chronic. The latter has little tendency to cease spontaneously, but causes thickening of the tendon-sheaths, steady increase of their contents, and hence difficulty in movement. Both varieties are more frequently met with in females than in males;

the parts most liable to attack are first the fingers and toes, next the region of the biceps and peroneus, and lastly the knee-joint.

Syphilitic Diseases of the Bursa Mucosæ are less known than any others included in our subject. Keyes has only observed them in the gummy forms. Recognizing, according to our previous classification, an irritative variety as well, we are able to adduce from our clinical records a fine example of

(a) *Acute Bursitis*.—Developed as a painful, plainly fluctuating swelling, interfering with every movement, but not communicating with the joint, and which yielded to potassic iodide.

(b) Also, one of præpatellar *Gummy Bursitis*. This presented a painless, tense tumor, either originating in the bursa itself, or seizing upon the latter from an adjacent part, which, after lasting several months, finally softened at its centre; from thence the infiltration extended to the outer integument, which first turned livid and thin, then broke, and disclosed a deep ulcer with solid contents.

This affection is more frequent in women than in men, and usually occurs in the knee-joint.

PERIOD OF APPEARANCE.—DIAGNOSIS.—No fixed rule is observed by the diseases we are considering as regards the period of their appearance during the course of constitutional syphilis. This, however, is certain: that, from the date of the earliest specific eruption, until the last lurking trace of the contagion has been banished from his system, no syphilitic subject is secure against their occurrence. Since, in general, the irritative forms of syphilis are signs that the disease is still recent and in its acute stage, we are authorized in ranking the corresponding varieties of specific arthritis, etc., before the gummy lesions, in the order of their development. They may be said to make their earliest appearance within the first two or three years after infection. They become less acute the longer the constitutional disease continues, so that at the end of the secondary stage, or the beginning of the tertiary, the subacute and chronic forms are to be looked for in their stead, such as dropsy of the joints and tendon-sheaths. Finally, the gummy varieties are manifestations of syphilis rendered inveterate by the lapse of years.

As to the question of diagnosis, characteristic symptoms and morbid appearances can no more be assigned to the irritative forms of these affections of the joints, tendons, and bursæ mucosæ, than to a hepatitis or nephritis diffusa syphilitica. On the other hand, many of their purely syphilitic varieties present peculiar features, among which the thermometric variations, and the absence of complications on the side of the serous membranes, are the most significant. In a general way, it may be said that these syphilitic forms rarely attain to the intensity and degree of acuteness which mark the analogous non-specific rheumatic and traumatic ailments. Their diagnosis must rest upon the fact of their resisting all except specific modes of treatment, while responding promptly to the latter; upon the proof of their co-existence with the constitutional disease, and the exclusion of other causes. For the gummy varieties, we seek the evidence afforded by their specific morbid product, the gumma; or, failing this, must arrive at our judgment through a consideration of probabilities, as well as “*ex juvantibus*” and “*per exclusionem*.” The chronic character of these forms is suggestive of a diathetic influence, and here syphilis, scrofula, and tuberculosis should chiefly be taken into account.

Prognosis and Treatment.—Since the irritative forms we are now dealing with manifest no special characteristics, but display the same simply inflammatory symptoms as affections of a different origin, while still the fact is beyond dispute

that they may be produced by syphilis, it is incumbent upon the physician to bear the latter disease in mind when investigating their etiology, and should he suspect its existence, to adopt antisyphilitic measures. Especially is this his duty if he has previously tried every other kind of treatment without avail. As in other syphilitic cases, he will place his chief reliance upon mercury and iodine. In specific affections of the joints, etc., we generally prefer the iodine preparations to the simple mercury. Iodine, as the best anodyne and febrifuge in syphilitic complaints, is especially appropriate when there is great pain accompanied by fever. A liberal administration of potassic iodide—3.0 to 6.0 grm. pro die—will often cut short these latter symptoms at once, and if followed up by smaller doses—0.5 to 2.0 pro die—will soon put an end to the swelling and infiltration. Management of the chronic forms is a more difficult matter. Here, besides the energetic employment of mercury and iodine, resort must be had to more remote auxiliaries—baths of sulphur, iodine, and “sool”—in order to complete the cure. If, however, the mischief is so far advanced that connective tissue has formed in large quantities, while the cartilage is in great part worn away, and the articular capsule, the tendon-sheaths, and the walls of the bursæ mucosæ are very much thickened, lined with villi, or perhaps shrunken, then no satisfactory results can be expected from the most judicious treatment, but only a cessation of the morbid process, or, at best, a slight improvement. Prognosis is more favorable in the gummy varieties, which, so long as there are no disorganization and no cicatricial growths, may heal completely under specific medication; though, after cicatrices and new connective tissue have formed to any extent, these too must be regarded as hopeless.—ERNST FINGER, *Wiener Med. Wochenschrift*, 1884, Nos. 28, 29, 30, 31, 32, 33, 34.

INGROWING TOE-NAIL.

DEFINITION.—A chronic, painful, traumatic inflammation of the tissues at the margin of a toe-nail. The inflammation is usually attended with the formation of granulations and with suppuration, and it is nearly always of the great toe-nail, usually on its outer side. There is a form of so-called in-growing toe-nail which is not attended with suppuration, but is dependent on an accumulation of epidermic scales between the nail and the flesh; and very rarely, the disease may exist in one or other of the lesser toes.

CAUSATION.—In civilized countries, we must always recognize the element of compression, or at least prevention of expansion inside a boot. It is perfectly conceivable that the condition might exist in individuals who never wear boots, but for practical purposes we must take the boots for granted. They are a constant concomitant, and if not a prime, are probably a contributing cause. It is, however, a cause which we cannot remove. We must treat the toe inside the boots. Indeed, the patient will probably have removed the cause long before we see him. Looking beyond the boots, we find that the causes may be arranged as intrinsic, or depending on peculiarities in the toe or nail, and extrinsic, or dependent on the direction of the toes or the condition of outlying structures in the foot.

I. INTRINSIC, *i. e.*, in the nail, or in the surrounding tissues, or in both.

1. *In the nail.* In some people, the nails in the fingers and toes—and I have noticed that the peculiarity is usually coincident—are convex or arched, and dip deeply into the surrounding flesh. In such cases, in paring the nail of the great toe, it is difficult to carry the knife or scissors completely round, and thus there is frequently left behind a small spicule or pointed piece, which readily insinu-

ates itself into the neighboring flesh. Matters are sometimes made worse by pulling at this piece, "tearing it to the quick." The flesh swells and conceals this small piece of outlying nail; it is overlooked, sets up irritation, and the condition is developed.

2. *In the flesh.* Some people have a redundancy of flesh in their toes, and their fingers as well. In these the flesh overlaps the nail, and in the foot the confinement of the boot, added to the soddening perspiration under the overlapping flesh, readily starts the condition. Once started it continues, and suppuration along the margin of such a toe may continue for years. Fortunately, it is the least painful, and most easily treated of all the varieties.

3. *In both nail and flesh.* The existence of both the above conditions—an arched toe-nail and an excess of soft tissue—will frequently be found associated with the malady. Alone or in combination with extrinsic causes, this double condition, with the mere wearing of boots, is almost enough to cause this complaint. In this case also it is not likely to be severe.

II. **EXTRINSIC**, or from causes lying outside the nail and its surrounding tissues.

1. *Flattening of the arch of the foot.* Flat-foot, in varying degrees, I believe to be the most important cause of in-growing toe-nail, and all the more so that the ordinary modes of treatment are futile to cure it. It acts in this way through the attempt of the point of the great toe to become the anterior pillar of the arch of the foot—the natural support of the latter, viz., the pad at the root of the toes, particularly of the great toe, not being available on account of relaxation and perhaps painfulness of the plantar ligaments. But constant use of the toe in this wise induces hypertrophy of its tissues and consequent overlapping of the toe-nail. By easily understood stages this hypertrophy becomes irritation, inflammation, and suppuration where the flesh is crowded over the edges of the nail, and we thus get the condition fully developed.

It is simple flat-foot, *pes planus*, and not splay-foot, or *pes valgus*, which is most likely to start the mischief. And it has seemed to me that not the worst cases of flat-foot—those which require operation—but the moderate cases, which require no special treatment for the flattening, are chiefly associated with in-growing nail.

2. *Eversion of the great toe.* The production of this condition, I believe, will be most frequently found to depend either on a habit of walking with the limb much rotated outwards, or on a congenital deflection of the toe itself. This too great proximity may merge into a passing beyond, and then we have the second toe, perhaps with the third, overriding the great toe, and evidently causing the complaint.

3. *Inversion of the lesser toes.* In this case the same result as the preceding is produced by a deviation inwards of the second and third toes. How it is produced I do not know.

TREATMENT.—I. 1. Where the cause is intrinsic and resident in the nail alone, it may usually be remedied by careful attention to the "toilet" of the nail, using a knife rather than a scissors, and cutting from behind forwards obliquely, so as to give the nail a pointed shape. By this means, the leaving behind of sharp portions at the margin which are insinuated into the flesh is rendered less likely. If the granulations are exuberant, I would recommend the application of a crystal or two of chromic acid, which leaves a hard, dry scab, under which the sore heals kindly. Careful trimming of the nail will usually ward off the complaint in future.

2. Where the cause lies in a superabundance of flesh in the toe, a condition which is usually accompanied with thin, tender skin, which perspires and chafes readily, I believe the best plan to be: First, the application of chromic acid, if necessary, and thereafter pressure, either by strapping or by elastic. Every night the affected toe is to be surrounded tightly from the tip upwards by thin strips of adhesive plaster taken out of boiling water. This may be removed in the morning and replaced by an india-rubber cap, such as is worn over a sore finger during a *post-mortem* examination. The toe is thus rendered and kept anæmic by compression: congestion is removed, and the tissues get more firm and resisting in the course of a few months.

In such cases, I have sometimes noticed that the feet perspire freely, and then the wearing of fine worsted socks, the nightly use of a foot-bath, into which enough sulphuric acid has been poured to make the skin tingle, and sprinkling some powdered boracic acid over the foot every morning will expedite the cure.

3. When there is a combination of malformed nail and overgrowth of flesh, a judicious combination of the methods just described will probably effect a cure. Here, if anywhere, a scraping of the nail, making it thin and yielding, ought to do good; but I am doubtful of the utility of this procedure. The nail is too firmly bound down to the matrix to yield much to lateral pressure, and constant scraping, I think, has a tendency to develop an irritative hypertrophy of the nail itself. If all these or similar plans fail, there is nothing for it but removal of the nail in the manner to be described presently.

II.—1. Of intrinsic cases by far the most important is flattening of the arch of the foot, and unless this cause is clearly recognized and successfully met, our treatment will almost certainly fail. To restore the arch of the foot, probably the most scientific treatment would be to make the patient recline on his back for some weeks, and permit the stretched plantar ligaments to regain their tone. In actual practice it will be found a very efficient plan to wear a small pad of several thicknesses of chamois leather or flannel under the ball of the great toe. This pad may be put on every morning, and retained in position by a collar of thread or elastic carried round the root of the great toe. The toe, thus elevated beyond the reach of harm and relieved from its illegitimate labor, soon regains its normal condition. After a few months the pad may be gradually given up, and with care, the condition need not recur.

2. When the cause is eversion of the great toe, from whatever cause arising, the treatment is by no means easy. What I have found most satisfactory is a pad between the great and second toes, stopping short of the sore part. The pad may be constructed of several layers of flannel or chamois, and is kept in position by two collars round the root of the great and second toes respectfully.

3. I have seen only three cases of the second and third toes overlapping the first, and causing ingrowing of its nail. In these the condition was easily remedied by wearing a double band of tape, so arranged as to keep the two offending toes turned outwards and pushed downwards. The tape was fixed in a loop round the fourth toe, passing double over the second and third toes, and then surrounded the great toe. The little apparatus is easily made by the patient.

So much for the scientific treatment of the complaint. But there is a class of cases, chiefly among hospital patients, in which imperfect intelligence and want of cleanliness nullify our efforts. Such patients have usually flat-foot, but they want to get well at once and permanently, and the endless worry of the morning pad is beyond their endurance. For all these, I remove the matrix as well as the nail, and scrape the periosteum off the bone. The operation is certain to cure

permanently every case of the disease; it is a simple one, and by the exercise of a little dexterity, may be done on both feet while the patient is under the influence of nitrous oxide gas. The knife grazing the bone is carried rapidly round the flesh on the right side of the nail, and by a change of the same movement, passes under the nail down to the bone, and lifts away nail, matrix, and suppurating flesh. A piece of boracic lint is wrapped tightly round the toe, and need not be removed for a week. In the mean time the patient may get about. At the end of a week the sore will be smaller than the nail removed, for the healthy tissues have been pressed inwards over the sore. In three weeks the wound is cicatrized over, and most likely in a few weeks more a stunted nail is developed, like that usually seen on the fifth toe, from which no trouble ever arises.

If the patient is not anxious to have a handsome nail on his toe, I never hesitate to let him have this mode of cure. The loss of a toe-nail, at its best, can never be a great one; and when it is ingrowing its loss is a gain.

I confidently recommend the procedure as far preferable to mere avulsion of the toe-nail, a plan of treatment which, in my opinion, ought to be abolished from surgery.—J. GREIG SMITH, *Bristol Medico-Chirurgical Journal*, June, 1884.

HYPERIDROSIS AND BROMIDROSIS.

HYPERIDROSIS is an affection in which there is an abnormal functional activity of the sweat-glands. Many, especially corpulent people, who are otherwise in apparently perfect health, sweat excessively without apparent provocation, and are annoyed thereby to a greater or less degree, particularly in warm weather. The affection may occur in an acute form, and subside in a short time, but generally it is extremely chronic.

Hyperidrosis may be general or local in its manifestation.

Occurring over the whole surface of the body, it is not usually severe, but when limited to certain parts, it is much more noticeable, and constitutes a not uncommon and an extremely disagreeable affection. The palms, soles, and axillæ are the parts which are most apt to be the seat of the trouble, but the face and the genital regital region are not infrequently affected.

In rare cases, hyperidrosis occurs in a unilateral form. One side of the head, or one of the extremities, or even one-half of the entire body may be bathed in perspiration, while the opposite side retains its natural condition.

Hyperidrosis of the hands is not only annoying to the patient himself, but to those whom the social custom requires him to greet with a shake of the hand. Often, also, the affection prevents the sufferer from following any occupation involving the handling of fine textures.

Hyperidrosis of the feet is often associated with a similiar condition of the hands, but either may exist alone. When the feet are the seat of the affection, the stockings, however frequently changed, are kept moistened by the secretion, and even the leather covering of the feet becomes soaked in time. A disagreeable odor is usually occasioned by the chemical change which the secretion undergoes.

Treatment.—The predisposing causes of hyperidrosis should be diligently sought for in every case, and removed if possible. Nervous derangement and an impaired circulation are frequently underlying conditions which demand the most careful hygienic treatment. Among the drugs which have been recommended as capable of producing beneficial results in this affection are atropia and ergot. Small doses of jaborandi have also been employed with good effect in

both local and general hyperidrosis. As it is impossible in many cases to determine the precise cause of the disorder, we are generally forced to depend largely upon external applications, many of which give immediate relief, and in time subdue the excessive secretion. When the sweating is general, baths containing sea salt or carbolie acid may be employed, or portions of the body rubbed successively with a soft sponge dipped in the following lotion:

Sulphate of quinine..... 5 parts.
Alcohol.....to 500 “

M.

In hyperidrosis of the axilla or genital region, the skin may be bathed with a strong solution of tannin or alum, and after careful drying, the following powder dusted over the surface:

Salicylic acid.... 3 parts.
Starch ... 10 “
Talc powderto 100 “

M.

For the hands and feet, a similar plan of treatment is useful. Another excellent remedy is the subnitrate of bismuth, rubbed well into the skin after bathing, or dusted over the inside of the gloves or stockings. Hebra advised a plan of treatment which, if properly carried out, usually affords immunity from the annoying secretion for a considerable time, if it does not effect a cure. This plan consists in spreading diachylon ointment upon pieces of linen, with which the fingers and toes, as well as the rest of the hands and feet, are carefully enveloped. This dressing is to be re-applied twice daily for a week or two, the hands not being washed in the mean time. The application causes an exfoliation of the epidermis, leaving the skin soft and comparatively dry.

BROMIDROSIS is an affection in which the perspiration is characterized by a peculiar and usually an extremely disagreeable odor. The normal perspiration has always a slight odor, although this may not usually be perceptible to the average sense of smell. In disease, also, the perspiration is frequently changed in character, and various affections have been supposed by some to have each its distinct and characteristic odor. Certain persons, whose skin is perfectly free from disease, and whose general condition is good, exhale from their bodies a peculiar odor, which seems to be natural to them.

In bromidrosis, the secretion may exist in normal amount, or it may be in excess. The latter is commonly the case upon the feet and in the axillæ, in which case we have simply hyperidrosis with a foetid odor. This odor may not be due to any change in the composition of the perspiratory secretion, but usually results largely from the decomposition of the sweat which has soaked into the clothing of the part. In bromidrosis of the feet, even the shoes may be become saturated with the foul secretion.

The peculiar odor may also be due, in great part, to a peculiar secretion of the sebaceous glands, which becomes mingled with the perspiration. As the foetid secretion of bromidrosis is more irritating to the skin than a simple excess of perspiration, we find in this disease a marked tendency for the skin, especially of the feet, to become macerated and tender. Upon the soles the epidermis is always sodden, and often peels off in large masses, leaving an inflamed and often eczematous condition, through which locomotion is often seriously impaired.

Treatment.—The general treatment of bromidrosis is substantially the same as that of hyperidrosis, since whatever lessens the amount of the secretion, tends

to diminish the unpleasant odor. The more severe forms of foetid sweating are often checked by the adoption of such measures as promote the general health of the person affected. As palliatives, lotions, and dusting-powders of an antiseptic character have been found most useful in bromidrosis, especially when the disease involves the feet, as it is most apt to do.

For bathing the skin, a one-per-cent solution (five grains to the ounce) of chloral or permanganate of potash is both cleanly and beneficial. It should be applied with as little friction as possible, and allowed to dry upon the skin, or the excess of moisture may be removed by the pressure of a soft warm cloth. Ainsworth recommends the application of the following powder:

Dried alum.....	45 parts.
Salicylic acid.....	5 “

M.

Thin, of London, recommends the use of boric acid. The stockings should be changed twice daily, and the stocking-feet placed for some hours in a jar containing a saturated solution of boric acid. They are then dried, and may be worn again, the odor having disappeared.

Cork soles are to be worn during the day and soaked over night, like the stocking-fet, in a jar of boric acid.—GEORGE HENRY FOX, *Phil. Med. Times*, Aug. 23, 1884.

ETIOLOGY OF TRICORRHEXIS NODOSA.

ABOUT three years ago, I observed that numerous otherwise healthy hairs in the middle portion of both my whiskers were irregularly beset with minute whitish protuberances resembling the eggs of lice. These formations were only met with at some distance from the skin; wherever they occurred the hairs were slightly bent and cracked, or, in many instances, were broken off and ended in small whitish bulbs. In brief, the abnormal appearances were precisely those of the often-described tricorrhexis nodosa, and microscopic examination revealed the tissue-changes already supposed to characterize that disease. Evidence derived from the latter source led me to a conception respecting the origin of these phenomena, whose correctness is confirmed by the fact that I was enabled to prevent their reappearance on the after-growing hairs in the same situation. In a patient who sought treatment for a different complaint, I subsequently discovered the same capillary alteration, and was again successful in removing it. My practice, since then, having been of a more general character, I have no other case to report of this probably not infrequent affection. Nevertheless, I feel myself in a condition to affirm that habitual rough handling of the beard—as, for instance, hard friction with the towel after washing—will suffice to cause tricorrhexis nodosa in many persons. I have reproduced it purposely in one of my own whiskers, where I exhibited it to several colleagues, together with microscopical preparations from the same, which completely corresponded with those obtained by previous observers. My reasons for regarding mechanical ill-usage as the sole cause of this abnormality may be arranged under the following heads:

I. *Anatomy of the parts.* Outside of the characteristic prominences, the hairs are found to be quite normal in every respect. The microscope shows that at each one of the affected points the capillary substance has become fibrillated or unravelled, so that the opposing extremities of the two portions into which the hair-shaft is there divided, fit into each other, as a couple of broom-heads may be made to do. This condition, it has been hitherto assumed, is brought about

by some force acting from within outwards, but the fact that it can be produced at will in the case of any and every individual whose beard, like my own, is coarse and somewhat bristly, goes far to show that its cause is wholly external.

II. *Locality of the nodes.* Excepting in a solitary instance, tricorrhæxis nodosa has hitherto been observed only in the medullated hairs of the beard. It is easy to understand why the formation of the nodes is more likely to occur, from mechanical ill-usage, on such hairs as inclose a medullary tube, than on more delicate, and therefore more flexible hairs which have no such contents. To the former class belong the hairs of the beard, which, moreover, are comparatively thick and brittle—two other conditions which also favor the splitting up of their fibres, and the production of spindle-shaped or rounded prominences.

It is further to be noted that the section of beard chiefly liable to this disfigurement is that on which friction produces most effect, owing to the resistance offered by the underlying maxilla.

In some cases the disorder is seated on the moustache.

III. *The insufficiency of previous explanations.* By Wilks the phenomena in question were regarded as due to a fungoid growth; Schwimmer attributed them to disturbed nutrition of the hairs; Beigel, to the presence of air-vesicles; Eichhorst, to "hyperplastic" processes within the medullary cells, leading, in the first place, to fatty infiltration of the latter, and secondly to fibrillation of the cortical substance. In my opinion, it is this fibrillation which is the primary occurrence. It is readily conceivable that the fatty and almost fluid contents of the medullary cells should frequently be squeezed out by the rubbing and twisting to which the hairs are subjected, and, being pushed, in the form of lumps or drops, against the decorticated places in the latter, should give rise, at such points, to spindle-shaped swellings of the medullary substance. Conversely, also, the fatty contents are driven from the region of the protuberances into adjoining parts. The fat-granules, moreover, after escaping from the central channel, are here and there pressed against the cortex, and penetrate through the fibrillated portion of the latter, to the external surface of the hair.

IV. *The hitherto intractable character of the complaint* is easily accounted for, if we consider that it has been attempted to remove a disorder, originating in the manner just described, by the employment of friction (with spirituous fluids, irritating salts, etc.).—S. WOLFFBERG, *Deutsche Med. Wochenschrift*, July 31, 1884.

OLEATE OF COPPER; ITS EMPLOYMENT IN PARASITIC DISEASE OF THE SKIN.

TREATMENT of diseases of the skin due to the presence of a vegetable parasite has not heretofore yielded the most satisfactory results, owing chiefly to the lack of a drug or preparation which could be looked upon as a specific, or nearly such, that is, could be depended upon as capable of invariably effecting a cure. The oleate of copper, when *chemically pure*, would seem to be all that is required, and, in my experience, has answered every purpose most admirably, possessing none of the objectionable features alleged against it when manufactured from the formula contained in the United States Pharmacopœia. In the application of the improved oleate (which is practically of *full strength*) dilution is necessary, and this is easily accomplished by the addition of cosmolin, so that the varying strengths of *ung. cupri oleatis* may be readily encompassed.

The scope of usefulness of the remedy, so far as my observation goes, is confined to practically seven diseases, viz.: *tinea tonsurans*, *t. circinata*, *t. kerion*,

eczema marginatum—all caused by the same parasite; *t. sycosis*, *t. versicolor*, and *t. favosa*—each due to a separate parasite. My plan of treatment is as follows: if affecting a hairy part, first of all cut off the hair close to the skin wherever a diseased patch shows itself, the clipped area extending at least one inch, and oftener one inch and a half, beyond the margin of the advancing lesion. Having done this, the parts are then anointed with oil, fluid cosmolin (petroleum), or glycerin, or a bread-and-milk-poultice is applied. This for the purpose of dislodging scales or crusts if any be present. For the same purpose, when very much scurf or actual dirt is accumulated upon the parts, as is not infrequently the case, especially in public practice, I occasionally direct the parts to be thoroughly scrubbed with castile soap and warm water. Then an ointment of the oleate of copper, of a strength suited to the severity of the case, is prescribed and ordered to be rubbed into the diseased patches, gently but thoroughly, so as to procure as complete and rapid absorption as possible. If an exposed part, as in the case of ringworm of the head, it may be lightly covered with some appropriate material, or left bare, as the judgment and exigencies of the case dictate. The process of inunction should be repeated at least twice daily, this being usually amply sufficient. Unless an accumulation of scab-like substance should appear, it is not necessary or even desirable that the part be washed except at infrequent intervals. The following prescription illustrates the average range of strength in which the ointment is most frequently employed:

R Cupri oleatis ʒ i-vi.
 Ung. petrol. q. s. ad ʒ i.

M.

Between the two extremes above noted, I choose a strength which the judgment indicates as being best suited to the case. If the case be of a mild character, often seven or eight days suffice for a cure. If, however, it is severe, from ten days to three weeks, or, in exceptionally obstinate cases, even longer periods than this, may be required.

Some months ago, at my suggestion, some oleate of copper was prepared in the form of gelatin-plasters, which were used in a few dispensary cases. The effect was all that could be desired.

Up to January 1, 1884, no fewer than five hundred and twenty-three cases came under my observation. Eliminating the odd twenty-three cases, for purposes of convenience, a tabular analysis of the remainder exhibits the following as its more striking results:

Out of the total number, eighty-four cases occurred in private practice. Of these, about 86 per cent were caused by the *trichophyton tonsurans*. Of the four hundred and sixteen cases met with in public practice, no fewer than three hundred and eighty-nine, or about 93.5 per cent, were caused by the same agent—thus showing that of all the various forms of vegetable parasites, the *trichophyton tonsurans* is by far the most prevalent.

Epilation is rarely necessary in parasitic diseases where copper oleate is used. In favus, it must be confessed that the cure is retarded if epilation is not resorted to. This is the only disease of this nature in which the remedy has not produced a more rapid cure than other drugs. But I need not point out, as counterbalancing this, the preservation of partially good hairs and the suffering avoided: the facts are self-evident. Using the five hundred cases as a basis, I think better and quicker results, speaking in general terms, are obtainable by the copper treatment of the parasitic diseases than by any other plan. No better evidence of its

permanency is afforded than that every one of these cases was relieved *entirely*, not a single relapse having come to my knowledge.

In almost all cases of disease of the skin, be it parasitic or not, the patient is physically below par, and tonic treatment is imperatively called for. The proper supporting and reparative measures must vary, of course, with the exigencies of the case.

I have observed in a number of cases, probably not exceeding six or seven, a tendency to the formation of the so-called "blind" furuncles. In these instances the swellings developed after the application of the very strong ointment; but—and this is an interesting point—in many, if not all, the persons thus affected there existed a more or less well-marked tendency to a strumous diathesis. In consequence of this significant fact, the question has suggested itself to me whether the swellings would not have occurred with the application of any other remedy; if, indeed, they would not have presented themselves any way sooner or later through the aggravating influence of the morbid dermal state.—F. LE SIEUR WEIR, *N. Y. Med. Journ.*, August 30, 1884.

CUTANEOUS AFFECTIONS INDICATIVE OF THE HERPETIC DIATHESIS.

THE herpetic diseases constitute a class by themselves in dermatology. They are distinguished from all other cutaneous disorders by the most unmistakable signs. While the lesions of the syphilides and the scrofulides, even when the deepest seated and of the most serious character, are absolutely painless, and compatible with the normal exercise of all the vital functions, the slightest and most superficial manifestation of herpetism may be accompanied by sufferings so excruciating as to result in positive danger—witness those severe forms of lichen, prurigo, and eczema in which the intolerable itching often deprives the patient of sleep and appetite, and drives him almost into a state of frenzy.

Yet, notwithstanding the extreme distress which they occasion, eruptions of this latter class are sometimes necessary to the preservation of the general health. Their abrupt suppression may give rise, by metastasis, to internal disorders of the most obstinate character, and which, in fact, only cease on a reappearance of the cutaneous symptoms. These affections (psoriasis, eczema, lichen, prurigo) may, in certain cases, be regarded as salutary critical processes, both cleansing and revulsive in their nature, and therefore indispensable for maintaining the balance of the system.

While syphilis, during its protracted stages, recedes farther and farther from the integument, and narrows more and more the extent of its lesions; herpetism, on the contrary, becoming worse as time advances, goes on enlarging its hold upon the territory of the skin. Intermittent at first in its cutaneous manifestations, it establishes itself, later on, as a continuous and permanent affection; its initial lesions, starting as mere isolated points (psoriasis punctata, psoriasis guttata), finally overspread enormous tracts, which often comprehend the entire bodily surface (psoriasis diffusa, psoriasis inveterata, eczema universale).

Syphilis and herpetism, then, are absolutely opposed to each other in their progressive development upon the skin.

The various painful sensations (itching, tickling, smarting, lancinating, pricking) which are connected with the herpetic eruptions, the general distribution of those eruptions, their symmetrical disappearance, their tendency to relapse, their long duration, the dangers involved in their metastasis, their transmissibility by descent, such are the leading characteristics of this class of

diseases, and such, also, are some of the evidences which affirm the existence of the herpetic diathesis.—GUIBOUT, *Gaz. des Hôp.*, Aug. 7, 1884.

Review.

HANDBOOK OF THE DIAGNOSIS AND TREATMENT OF SKIN DISEASES. By ARTHUR VAN HARLINGEN, M.D., Prof. of Diseases of the Skin in the Philadelphia Polyclinic, and College for Graduates, etc. With two colored plates. Philadelphia: P. Blakiston, Son & Co., 1884.

As Dr. Van Harlingen tells us in the preface, this handbook is designed to meet the wants of the general practitioner. He confines himself to the description, diagnosis, and treatment of skin affections, referring but briefly to their etiology, and leaving aside all consideration of their pathological anatomy as foreign to the scope and plan of his book. The arrangement of the different diseases in alphabetical order is well adapted to facilitate ready reference. Another concession to the "wants of the practitioner" is made by treating at length "the commoner affections, and those giving most distress and annoyance to the patient," while the "rarer diseases and those causing but little trouble have been dealt with briefly." While we cannot commend this method of gauging the relative importance of different skin diseases—necessarily assigning an undue prominence to certain simple affections—yet it, no doubt, contributes to the object the author has in view.

We have before given our opinion of this class of books. This multiplication, however, is proof of their appreciation and indorsement by the profession. Dr. Van Harlingen's book compares favorably with similar works recently noticed in this JOURNAL, and is in some respects better. Its chief excellence is found in the therapeutical portion, which is brought up to the latest advances made in the practical department of dermatology. He gives a large number of formulæ embracing many new drugs, and combinations which recent experience has demonstrated to be of superior efficacy. His selections have been made with judicious care, and from many reputable sources. In this respect the book is superior to many larger and more pretentious works.

Received.

Dermatitis Herpetiformis, by L. A. DUHRING (Reprint).

Case of Dermatitis Herpetiformis aggravated by Pregnancy and irregular Menstruation, by L. A. DUHRING (Reprint).

Notes of a Case of Dermatitis Herpetiformis extending over eleven years, by L. A. DUHRING (Reprint).

Wo stehen wir heute gegenüber der Syphilis? Von H. AUSPITZ (Reprint).

Ueber Syphilis-Statistik, von H. AUSPITZ (Reprint).

On Urticaria Pigmentosa, by T. C. FOX (Reprint).

On Impetigo vel Porrigo Contagiosa, by T. C. FOX (Reprint).

Pathology of Paget's Disease of the Nipple, by L. A. DUHRING (Reprint).

A Manual of Dermatology, by A. R. ROBINSON, M.B., etc. New York, Bermingham & Co., 1884.

La Dermite esfoliativa Universale quale trasformazione del Psoriasi, by Prof. Dr. PIETRO GAMBERINI (Reprint).

Du Lupus et de ses rapports avec la Scrofule et la Tuberculose, par EMILE RENOUDARD. Paris, 1884.

A case of Universal Psoriasis, by A. H. OHMANN-DUMESNIL (Reprint).

A case of Symmetrical Vitiligo, by A. H. OHMANN-DUMESNIL (Reprint).

Album Clinico de Dermatologia publicadas por la Revista de Medicina y Cirugia Practicas. Lamina 1-26, Madrid, 1884.

Item.

DELUSIVE HOPES AND SKIN DISEASES.—DR. SHOEMAKER.—MAVERICKS AND A PLEA FOR DERMATOLOGY.—Dr. Brocq, correspondent for Piffard's *Journal of Cutaneous Diseases*, writing from Paris (August number), says the physicians, doctors somebody—don't remember names—are using chrysophanic acid *internally* and by hypodermic injection, *in all sorts of skin diseases*, with wonderful success. He gives a most marvellous showing of cases and results, some sixty odd cases, not only parasitic diseases, but *all sorts*, *cured* by this method.

Well, being especially interested in the subject, we felt good; we felt as if we had dropped on to something extra, something not generally known, and that hereafter curing little old cases of eczema and "tetter" was going to be mere child's play. As for the parasitic skin diseases, old *Tricophytosis* and *Favus* and *Chromophytosis et id om. gen.*—we felt already quite equal to them, but here was, according to Dr. Brocq, a simple remedy, a *specific* for *all sorts* of skin diseases, no matter of what character; and we really felt as if we would like Piffard's journal of that particular issue, all to get burnt up, for fear this valuable piece of information would become generally known, and that then *anybody* could cure skin disease as well, better than we could, and thus would the old fellow's occupation be gone.

But in our old age we are getting suspicious. We rather feared it was too good to be true; so, before rejoicing, we thought we would wait, and get entirely out of the woods. Accordingly, we wrote to Dr. Shoemaker, the Philadelphia dermatologist, and asked him if it was "so"; if *he* had found chrysophanic acid, internally, a specific for skin diseases of all sorts. Now, of course, we didn't believe it was worth a cent, in any other class of diseases than the parasitic; we know it is useful in ringworm and other parasitic diseases externally, but its use for any other kind must be entirely empirical.

The doctor promptly and courteously replied that he had read the same article, and had given the chrysophanic acid a thorough trial. He gave it in $\frac{1}{4}$, $\frac{1}{2}$, and 1 gr. doses *per orem* (had never used it hypodermically). He found it to be

an active cathartic; indeed, in proportional doses, a violent purgative; and that it had no other effect on the system. The skin disease got better immediately, as it will generally do under the administration of any irritant to the intestinal mucous membrane, but would resume its *status quo* on withdrawal of the medicine.

So, thus vanishes and fades away another bright hope which had cheered us a brief while.

By-the-by, the classification of skin diseases is very unsatisfactory; the treatment still more so. We should rather say the *various* classifications, for they are numerous, so numerous as to be misleading. The average doctor has a classification of his own, in which "eczema" largely predominates. In fact, everything that isn't something else is eczema; and with the general run of doctors there are only about two or three something else. "Tetter" (whatever that is) is another large class, under which head goes a great many unrecognized diseases. A patient comes in: "ringworm" and "shingles" are excluded, differentiated, and the case is immediately classed as "tetter," or "eczema." We remember an obstinate case of herpetic eruption of a syphilitic nature, which promptly yielded to appropriate treatment at our hands, which had been treated *five years* for eczema; and also several cases of "tetter" (the laity call everything scaly or itchy: "tetter"), which we were enabled to dispose of simply by making a correct diagnosis.

Out here in Texas, all the unbranded calves are called "mavericks." Eczema is the maverick of skin diseases. If it isn't something else, some other brand, it is eczema. Eczema is the proteus also of skin diseases. A doctor knows that, in pronouncing a skin eruption "eczema," he has about forty chances in his favor of being right; if he calls it "tetter," he has about the same ratio. He accordingly prescribes Fowler's solution or iodide of potassium, sulphur or zinc ointment, may be uses some of the mercurials locally: and if in about six weeks the disease does not disappear, the doctor recommends the patient to go to Hot Springs.

Now this is all wrong. There are excellent works extant on skin diseases, illustrated with most faithful photographs, which, if properly studied, would enable any intelligent physician to have much better success in treating this obstinate class of diseases than now attends their efforts. The fact is, it is a difficult subject and a difficult study; and too often the *pay* is not commensurate with the labor and study; hence the subject, this important subject—one which seriously affects the health, happiness, comfort, and well-being of a large class in every community, is neglected; or, if attended to, it is slouched over—not thoroughly done, by a great many intelligent general practitioners.—EDITORIAL *Texas Courier-Record of Medicine*, Nov., 1884.

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Original Communications.

NOTES ON THE TREATMENT OF AN EPIDEMIC OF RINGWORM OF THE SCALP IN A PUBLIC INSTITUTION.

BY

W. T. ALEXANDER, A.M., M.D.,

Surgeon to Charity Hospital.

“TROUBLESOME and disappointing as the management of ringworm in ordinary practice is, it is infinitely more so in schools and public institutions.” This statement, which forms the opening sentence in an article by the late Tilbury Fox, on “Ringworm in Schools” (London *Lancet*, January, 1872), has since been corroborated by a number of writers, and doubtless correctly represents, if I may judge from verbal communications with many dermatologists, the experience of all who have had much to do with the treatment of the disease in question. It at any rate emboldens me to contribute my small quatum of experience with the subject, in the hope that a plan of treatment which I have recently been pursuing may prove equally satisfactory in other hands.

The true reason for the tronble and disappointment which attend the management of ringworm (of the scalp) in ordinary practice is doubtless the uncertainty attending the prognosis of the disease. This is well expressed by Alder Smith (“Notes on Croton-oil Treatment of Ringworm,” *British Medical Journal*, June 12, 1880, p. 885), who says that “it is most difficult to certify that any case of this disease is absolutely well. Time after time stumps that were not visible at one examination will crop up again, breaking off when any attempt is made to extract them, and reappearing again and again for months after the case in other respects seems cured.” Since even in isolated cases the disease often runs

on for six months or a year or more, despite reasonably thorough treatment, owing to the difficulty of determining with positiveness the period at which the case may be pronounced cured and a suspension of treatment advised, the difficulty is greatly increased when the patient is constantly surrounded by other cases of the disease, and lives in rooms the atmosphere of which is loaded with the germs of the fungus, as Tilbury Fox believed he had demonstrated.

The local measures on which reliance is usually placed to cure the affection as it occurs on the scalp, where it is notoriously much harder to deal with than when it is seated on the non-hairy portions of the body, are thorough cleansing of the parts, removal of all the hairs from the affected spots, and the application of agents possessing parasiticide qualities. Prominent among these are various preparations of mercury, sulphur, tincture of iodine, sulphurous and acetic acids, and vesicating agents. These are all used in the form of ointments or lotions, the application of which requires time and patience, and must be repeated once or oftener daily. That these and similar agents, which in the majority of instances succeed in curing the disease, do not always do so, is doubtless due to the difficulty of bringing them into direct contact with the parasite which is often found at the very bottom of the hair follicles.

Of late years a number of authors, attempting to utilize the fact of common observation that the vegetable parasite which causes the disease cannot live in the presence of pus, have advocated and practised in chronic, obstinate cases, the artificial production of the variety of the disease known as kerion. The agent which has been most used for the purpose is croton oil, painted upon the diseased patch until pustulation and deep-seated suppuration were produced. Alder Smith, who strongly advocated this plan of treatment, says that "care should be taken not to produce an actual slough of the upper part of the corium," and that sometimes, when even this powerful agent fails to cure the disease, he uses tartar emetic ointment as well, or equal parts of the bichloride of antimony and lard, which is most intensely escharotic, and always produces a bald place by destroying the follicles." But even this sometimes fails, and he believes that "there are undoubtedly inveterate cases that cannot be cured, but such always get well spontaneously about 15 or 16."

That this plan of treatment is heroic and severe in the extreme is, I think, evident to every one who has seen many cases of kerion, or the acute inflammatory form of ringworm of the scalp. An insignificant painless scaly patch is by this treatment suddenly converted into an œdematous, boggy, elevated mass covered with suppurating points and discharging a glutinous fluid, tender and painful, and generally the seat of intense burning and itching. If this condition last long, as it often

does, the hair-follicles may be destroyed, and permanent baldness and even cicatrization result.

I by no means deny that this plan of treatment may be effectual. But that it is needlessly severe, and even barbarous, I am strongly inclined to believe; especially in view of my experience with the disease during the past year, and its treatment by a measure the description of which is the sole object of this paper.

About one year ago I was requested to undertake the management of a number of cases of ringworm of the scalp in a large orphan asylum in this city. On my first visit about twenty children were brought forward, all under the age of twelve. On the head of each were one or more spots presenting the macroscopical appearances of typical trichophytosis. Specimens of hairs and scales were removed from each, and subsequent microscopic examination revealed the presence of abundant spores and mycelia of the trichophyton tonsurans, the former largely predominating. Inquiry showed that the method of treatment which had for a long time been followed in the institution, under the direction of two very skilful physicians, was isolation of the patients, cutting the hair, washing the heads, epilation of the patches, and the frequent and thorough application of a lotion of corrosive sublimate in some cases, and in others sulphur ointment. Careful inquiry and observation showed me that all these measures were properly applied, the lotion being briskly rubbed into the scalp with a small mop, in some cases several times daily. The hygienic surroundings of the institution were of the best, the food, sleeping apartments, and conveniences for cleanliness being all that could be desired. But in spite of everything, relapse after relapse occurred, and the attendants had begun almost to despair of ever being able to arrest the spread of the disease, which was rapid.

Investigation soon showed me that in the already crowded state of the hospital wards, complete isolation of the diseased children could not be carried out. Many of the least advanced cases were living in the main building, in which new cases were discovered nearly every day, in spite of the fact that all the patients wore caps.

Complete isolation of the patients being out of the question, the possibility of isolation of the disease was next considered, and it was believed, from past experience with the agent, that the use of *Liquor Guttaperchæ* of the *Pharmacopœia* would accomplish the desired end. This substance, to the use of which in cutaneous therapeutics attention was first publicly called, I believe, by Ausspitz,¹ has the property of forming a thin artificial cuticle, which, unlike collodion, exerts no tension, does not become brittle, cannot be easily rubbed off, remains intact for sev-

¹ Med. Klinisch. Wochenschr., Aug. 4, 1883.

eral days, and is, I believe, impermeable. This last quality would, it was thought, give it an additional value when applied to a patch of ringworm, as by its use the supply of oxygen necessary for the life of the fungus would be cut off. It was thought desirable at the same time to apply with the gutta percha a reliable parasiticide, and the one chosen was the well-known chrysarobin. This agent was long ago used in parasitic affections of the skin by Fayrer, Simon, Smith, Liveing, and others, in the form of an ointment, but its use in this manner was attended with so many drawbacks that it was by many abandoned. As I had found that these objections to its use, such as the staining of hair and clothing and the production of dermatitis, could be almost entirely obviated by applying it in the form of a pigment with the gutta-percha solution, I saw in them no contra-indications to its use in the present instance. An additional reason for using it was that it possesses in an eminent degree the faculty of producing what is usually aimed at in the croton-oil treatment of ringworm, viz.: the power "to produce an inflammation involving tissues at least to the depth of the hair-follicles."

In using the pigment of chrysarobin (of the strength of ten per cent in *Liquor Gutta-perchæ*) it was hoped that three objects would be accomplished, viz.: the isolation of the patches of diseased skin, the exclusion of oxygen from the fungus, and the direct destruction of the latter by the action of the parasiticide. The method of using it was as follows: The hair was closely cut or shaved on all the heads which presented scaly patches; the scalp was thoroughly cleansed, and epilation by forceps of the hairs on the spots and for a short distance around them was practised. This left a clear, bald spot, the centre and greater part of which was thickened, infiltrated and of a dark-gray color, contrasting sharply with the healthy skin around it. This discolored area was then covered with a layer of the pigment applied with a stiff brush. Nothing further was done until the artificial cuticle began to crack, or until the growing hairs pushed their way up through it. The application was then renewed, and this was done twice or thrice a week. No attempt to isolate the patients was made, and no other precautions taken except to make them wear caps, to insist on frequent inspections and thorough cleanliness, and to attend to their general health. Cod-liver oil or iron were administered to such as seemed to require them.

The effect of this plan of treatment, which was at first used cautiously and with some misgivings, soon became apparent. The great diminution in the amount of attention required by each patient was exceedingly gratifying to the overworked attendants, and they were enabled to devote much greater care to seeking for new cases. The number of these among children who had been for some time in the institution soon

¹ W. Cottle, *London Lancet*, May 1, 1880, p. 697.

began to diminish, and in a short time only the recent arrivals would be found to present evidences of fresh attacks of the disease. Every head was carefully examined at frequent intervals, and each scaly patch was at once covered with the yellow pigment, in many cases without previous epilation. After this plan had been followed for two or three weeks, the matron of the institution, whom I found to be a most careful clinical observer, remarked to me one day: "Doctor, that yellow paint seems to kill the ringworm at once." So much pleased was she with it in fact, that at my occasional visits I found that there was but little need for my services, all the cases of even suspected ringworm being submitted in a routine way to the treatment, without awaiting a positive diagnosis, and all, with but few exceptions, doing well. The exceptions were rare instances in which a pustular dermatitis was set up by the pigment, and in these, of course, its use was suspended. In many of the fresh cases one or two applications of the mixture, without epilation, at once put an end to the disease.

Occasional relapses did occur, of course, but they were always due to the premature (as it proved) suspension of the treatment and the substitution of inunctions with carbolated vaseline. A return to the pigment and the continuation of its use for a number of weeks longer, generally sufficed to complete the cure. A number of cases of the pustular dermatitis mentioned above (which sometimes spread over the entire scalp) were the only unpleasant effects of the treatment, but in not a single case was a true kerion produced. That the epidemic has been entirely stamped out at the date of this writing I cannot claim, but at a recent visit to the institution, although I saw a large number of children with the familiar yellow spots on their heads, I was unable to recognize a single well-marked case of ringworm. The application of the pigment to every scaly patch has become a routine practice in the asylum, and doubtless a number of cases of squamous eczema have been regarded and treated as ringworm. Another curious fact about the epidemic has been that only two or three cases of ringworm of the non-hairy skin have been found during the year.

Although my experience with the plan of treatment detailed has not been sufficiently large to enable me to assert that it will cure all cases (probably not more than sixty patients having been treated during the epidemic), yet I feel warranted in recommending it for trial, in the confident belief that it is capable of radically curing a large proportion of cases of this disease (and doubtless also of favus), with a minimum of trouble to the attendants, and of suffering and annoyance to the unfortunate victims of this exceedingly troublesome malady.

CANITIES.

BY

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SYNONYMS :—Trichonosis cana; Trichonosis discolor; Poliothrix; Poliosis; Trichonosis poliosis; Trichosis poliosis; Spilosis poliosis; Poliotēs; Grayness of the hair; Whiteness of the hair; Blanching of the hair; Atrophy of the hair pigment.

Grayness or whiteness of the hair may be congenital or acquired; and of these, the latter is by far the most common. The whiteness is either partial or complete.

Congenital canities usually occurs in the form of tufts, sometimes in round patches, the more or less pure white hair showing conspicuously amongst the normal-colored mass. When the whiteness is general, we have albinism which is associated with a deficiency of pigment in the whole body. Cases of congenital canities are rare.

Acquired canities may be premature or senile. Most often grayness does not begin before the thirty-fifth to fortieth year. If it occurs before this age, it may be considered as premature; and when after this age, as senile. Premature canities is by no means uncommon, many persons becoming gray between the twentieth and twenty-fifth year. The hair which, as a rule, first whitens is that of the temples; then follows, with more or less rapidity, that of the vertex and whole head. Sometimes the beard first turns gray, but usually it changes color after the hair of the scalp. The last hair to become gray is that of the axillæ and pubis. When the graying is due to some passing cause, as anxiety or some diseased state, the process may cease completely upon removal of the cause. Instances have been noted of normally-colored hair growing in after the fall of the white hair, but usually the whiteness is permanent. When graying of the hair is due to senile changes, it is progressive and permanent. As a rule, there is no change in the color of the scalp, though in some cases gray tufts are found upon pale-yellow patches of scalp. As in alopecia, so in canities, men are more frequently affected than women.

The hair in canities is usually unchanged except in color, but it may be drier and stiffer than normal. Canities may exist for years without alopecia. In the senile form, alopecia is apt to come on as another senile change; alopecia senilis, as is well known, is generally preceded by canities. According to Landois, incipient baldness usually follows senile canities in from one to five years.

The hair turns gray first at its root, and not at its point, as has been maintained. The color at first is gray on account of the mixture of the

normal color and the whiteness due to the absence of pigment. Gradually, the white parts gain the ascendant, and the whole hair is blanched, becoming finally of a yellowish or snowy whiteness. The darker the hair is originally the more it is prone to turn gray.

Sudden change of color of the hair from its normal hue to perfect white has been too well authenticated to allow of a doubt as to its occurrence, though it has been denied by good authorities, who have questioned the correctness of the observations reported.

Leonard¹ gives a long list of cases, including those of Marie Antoinette, Mary, queen of Scots, and others. Landois² reports fully a case of this sort observed by himself. It occurred in the person of a man, thirty-four years of age, who was admitted to the hospital suffering with delirium tremens. His delirium took the form of great terror whenever any one approached him. On admission, his hair was of blonde hue, and was so up to the evening of the third day. On the morning of the fourth day, the hair both of the beard and scalp was noticed to have become gray. Some of the hairs were white from root to point, some only at their roots, some only at their points, while some were white and blonde at different points. A careful perusal of the reported cases will be sufficient to convince one of the reality of sudden blanching of the hair.

Ringed hair is an anomalous variety of blanching of the hair in which the affected hairs are marked by alternate rings, one being that of the normal color, and the next white. The occurrence of this disease is very rare, and but few cases have been reported.³ In Wilson's case, the disease had been progressive for six years and affected only the scalp hair. The white portions occupied the entire diameter and were opaque by transmitted light.

The hair has been known to lose its color under varying circumstances. Thus Wallenberg⁴ reports a case in which, after an attack of scarlatina, the patient's brown hair was entirely lost and replaced by a growth of white hair. Prolonged residence in a cold climate, with much exposure, will cause the hair to turn gray. Sometimes the hair will change its color with the season, becoming gray in winter and darker in summer.⁵ On the other hand, Cottle⁶ gives prolonged residence in hot climates, with much exposure, as a cause of canities. Albinos, we know, are most frequent in the negro races, which inhabit the hot countries.

¹ "The Hair, its Diseases, and Treatment." Detroit, 1881.

² Virchow's Archives, 1866, xxxv., 575.

³ Wilson, E., Tr. Roy. Soc., 1867: also see "Healthy Skin," London, 1876, p. 109.

⁴ Arch. f. Derm. und Syph., 1876, Heft 1.

⁵ Wilson, Lect. on Dermat., 1878, p. 171.

⁶ "The Hair in Health and Disease," London 1877.

Etiology and Pathology.—Senile canities and many cases of the premature form are due to an obscure change in the nutrition of the hair papillæ which interferes with the production of pigment. Whatever the nature of the change may be, only this function of the papillæ seems to be interfered with, as the hair-forming function is in full activity, judging from the fact that the hair in many cases is in full vigor. The hair depends, for its shade of color, upon the color of the hair cells, upon the color of the hair pigment, and upon the amount of air contained between the hair cells. It is from the outer layers of the hair that it chiefly takes its color tone. Thus often under the microscope a large amount of pigment cells will be found in the medulla of a hair that appears white. In cases of sudden blanching of the hair, the change of color is dependent upon the formation of air bubbles between the hair cells of the cortical substance, the presence of the air rendering the cortical substance opaque, so that the color of the pigment is obscured. If one of these hairs is placed in hot water, ether, or turpentine, the air bubbles will be driven out, and the hair will reassume its normal color. This same infiltration of the hair with air will be found also in some cases of ordinary premature canities, though most of such cases are due, as above stated, to interference with the production of pigment. According to Pineus,¹ in the beginning of canities the pigment slowly leaves the middle layers of the papillæ and remains alone in the external layers. With the increase of the canities, only a portion of the external layer of the papillæ will produce pigment, which in straight hairs will run in streaks parallel to the long axis of the hair, and in curly hairs will run in a spiral. The blending of the colored and uncolored streaks will produce the gray color, which will gradually change to white as the pigment is less and less produced. There are various agents which act as active or exciting causes of canities. Age is one of the most prominent of these. Heredity exerts marked influence upon the blanching of the hair, most of the members of certain families turning gray at an early period of life. Neuralgia of the fifth nerve, dyspepsia of various forms, sudden fear or nervous shock (producing sudden blanching of the hair), abundant and frequent hemorrhage, excesses of all kinds, chronic debilitating diseases (as syphilis, malaria, and phthisis), local diseases or injuries to the scalp, as wounds, favus, repeated epilation, prolonged shaving, and the like, have been given by various writers as causes of canities. Schwimmer regards it as being principally a tropho-neurosis, and finds in the occurrence of grayness in the course of neuralgia a strong argument for his theory.

The cause of "ringed hair" is ascribed by Wilson to the development of a gaseous fluid within the hair, and he thinks that either the white, opaque and smaller segments were developed during the night, and the

¹ Arch. für Derm. und Syph., 1872. ii., 1.

larger and normal segments grew during the day; or, the separate segments were the product of alternate days. The gas may have been generated at the time of the formation of the abnormal segment, or the cells which composed that segment may have been originally filled with an aqueous fluid which evaporated quickly, and was replaced by air penetrating from without. Landois¹ does not think that the white places are the products of the growth by night, and the dark by day; nor that the white places were due to drying of the hair elements. He believes that we must assume an intermittent activity of the trophic or vaso-motor nerves of the papillæ through whose influence a hair tissue is formed, in which a periodic development of gas takes place. The solution of the question is still in abeyance.

Treatment.—We cannot restore the color to gray hairs. In some cases of canities occurring in the course of neuralgias, if we can cure the neuralgia, the color will gradually return to the hair.

All that can be done for canities is to artificially restore the color by means of hair dyes; and their use is to be deprecated. Happily the custom of dyeing the hair is falling out of fashion. We append a few formulæ for hair dyes, selected out of many.

Hair Dyes.—Hebra and Kaposi give directions for the process of dyeing the hair black by “Henna.” This is made into a paste with water and spread upon the hair. In an hour the hair will be red. Then a paste is applied to the hair made from powdered indigo plant. Then damp heat is applied, and in a few hours, if experience and good judgment have regulated the process, the hair will have a fine, black color.

Leonard gives the following preparations for dyeing the hair black:

No. 1.

℞ Bismuthi citratis.....	℥ i. = 32.
Aquæ rosæ,	
Aquæ destillat.....	āā ℥ ij. = 64.
Alcoholis.....	℥ v. = 20.
Ammoniæ.....	q.s. = q.s.

Sig. Apply in the morning.

No. 2.

℞ Sodii hyposulphit.....	℥ xij. = 48. (60.)
Aquæ destil.....	℥ iv. = 128. (140.)

Sig. Apply in the evening thoroughly to the hair.

Nitrate of silver may be used in the strength of from five to ten grains to the ounce, saturating the hair with the solution, and allowing it to dry in the sun, or in the light in a warm room. If it is wished to hasten the process, an application of sulphuret of potash, of twenty grains to two drachms to the ounce of distilled water, will cause the dye to set instantly.

¹ Virchow's Archiv, 1869, xlv., 113.

Gloves should be worn when applying this dye, and a brush used to lay it on.

Lead may be used in the form of the sugar of lead, ten to twenty grains to the ounce of water, applied to the hair, and when about to dry following it up with a solution of sulphide of ammonium about one quarter the strength of that of the British Pharmacopœia.

Mercury may be used in the form of the bichloride three grains to the ounce of water brushed through the hair and followed when dry with a solution of hyposulphite of soda, one ounce to two ounces of water. The last two dyes are dangerous. For a brown dye Pfaff recommends a pomade composed as follows:

R	Ol. ovorum rec. press.,	
	Med. oss. bovis	āā 50.
	Ferri lact.	2.50.
	Ol. cassiæ ether.	1.50.

The number of dyes is legion, and the above must suffice as examples. Before the application of any dye, the hair should be thoroughly cleansed with soap and water.

CHRONIC PRURITUS.

BY

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IN January, 1884, Mrs. E. H. D., aged thirty-one, presented herself at my clinic for skin diseases at the Woman's College. She stated that the eruption on her body had existed since early childhood and had been treated by several physicians, with only partial relief. Inspection showed the greater part of the body, particularly the extensor surfaces of the legs and arms; the neck, face, back, and breast, was covered with numerous brownish pigment spots, ranging in size from a quarter to one-half inch in diameter. The spots were round, oval, or irregular in outline, and have remained in this pigmented condition for many years. Closer inspection revealed a slight depression in the centre of these stains. Many have undergone atrophic changes and now present pearly-white cicatrices. On the breast, where the irritation first appeared when she was a child, the pigment has become entirely absorbed and there exist a large number of small depressed cicatrices that resemble somewhat the pitting of small-pox. It seems rather remarkable that the part of the body usually in ladies covered by the corsets, has a very few, if any, lesions. She has informed me, however,

that this region has by no means been exempt from the irritation, but the thick covering has prevented the free use of the finger-nails whenever she might have a desire to scratch. The macules so far described are unquestionably secondary lesions, and have been produced by the finger-nails. She informed me that a certain part of the body would itch to such an extent that she could get no relief until the spot was scratched out, and as she now regards the pleasure of scratching no particular compensation for further delay she immediately commences the lacerating process. I have most carefully, and on different occasions, examined the skin for some manifestations worthy to be called primary lesions, but they evidently are not to be found. I am, therefore, led to believe that we have to deal with an aggravated and exceedingly chronic pruritus. I am not certain as to the true cause of this affection, although it would seem from the treatment that the nervous system was mainly at fault. She certainly has no organic disease that can be discovered, and the different functions of the body are carried on in a healthy manner. Careful and repeated examinations of the urine have been made, but no abnormal products have been found that, as far as we know, could in any way influence the disease. The lady has two children, the elder a boy in good health and without any history of cutaneous disease; the younger, a girl, two years of age, healthy, rosy, and plump, and without the slightest appearance of any cachectic condition. Three months ago this child commenced scratching the skin, and it was for her relief that the mother again consulted me. Examination revealed a few isolated pigmented spots on the legs and arms, and with the same peculiar depressed centre that has already been described in the mother. The mother informed me that she had closely watched the parts when the child was in the act of scratching, but could see nothing upon the skin. In my recent examination I have not been able to detect any primary lesions such as may be observed in prurigo or lichen planus. These cases are not only unique, but offer peculiarities for speculation. The fact that the pruritus has existed during the life of the mother, and, as she affirms, a similar eruption was present upon the body of her mother, a child of a later generation also similarly affected, shows a peculiar persistency and a seemingly hereditary transmission. For the benefit of any one who would endeavor to explain these local phenomena by the unsuspected existence of a few scattering pediculi, it must be said that, for the present at least, there is no evidence whatever of their presence. Another argument against this supposition is, that the little brother, who occupies the same bed, has no cutaneous disease visible. It is not necessary to take up valuable space in your journal in giving a complete synopsis of the treatment so far instituted. It is sufficient for the present purpose to state that we have endeavored

to allay the irritability of the skin by different combinations of anti-pruritics. The best remedy so far used has been a solution of naphthol. It certainly has proved a great boon to her irritable skin, and she now receives almost complete relief. During the months that I have had her under treatment she has also taken internally a combination of iron, arsenic, and nux vomica. This treatment, given at intervals, has given tone to the nervous system, and has proved a very important adjuvant to the local measures. The treatment up to this time has so far controlled the pruritus that an ultimate recovery may be reasonably expected.

CHICAGO.

FAVUS IN AN INFANT.

BY

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ROBERT BERRY, healthy, well-developed infant born March 19, 1883, weight at birth six pounds two and one-half ounces. Mother primipara, twenty-three years of age, always healthy. No family history of skin disease. A few days after birth, a red spot was noticed on right side of infant's head, circular in form, about five lines in diameter. Did not increase in size or present any characteristic appearance for the first four weeks after birth, when a small yellow cup-like disk, having well defined border, appeared in centre. This gradually increased in size and was followed by others. No treatment was given until infant was seven months old; at this time the original spot had increased somewhat in size, and in addition had sent out a spur-like prolongation posteriorly, eight lines in length by two in width. This as well as the circular spot was covered with favi of varying size numbering in the aggregate fifteen.

At this time the patient was first seen by Dr. Piffard, who pronounced it a case of favus, and confirmed the diagnosis by making a microscopical examination of one of the cups, finding the *Achorion Schœnleini* in abundance. Treatment—Removal of crusts. Painting surface with tinct. iodine. This was continued at intervals of from two to three weeks according to appearance of favus cups; the surface affected gradually becoming smaller and intervals longer before the appearance of the favi.

Seven paintings in all were resorted to, when the cups entirely disappeared leaving a slightly reddened surface. At this time the little patient left the Asylum and passed from observation.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

150TH REGULAR MEETING, DECEMBER 23D, 1884.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. ROBINSON presented a case of

SYCOSIS.

William C. has had the present eruption for six years, on both sides of the face and the right temporal region. The patches on the cheeks are sharply limited, there are no vesicles, no exudation on the free surface, *i. e.*, no signs of catarrhal inflammation, but dark-red corium infiltrated—a parenchymatous inflammation with isolated peri-follicular pustules and indurated tubercles.

On the temple the eruption is chiefly confined to isolated hair-follicle areas.

On the chin a parenchymatous inflammation with less infiltration than on the sides of the face, and with many pustules perforated by hairs.

The eruption has always remained confined to the bearded portion of the face and the right temple, commencing in the latter situation.

The inflammation has periods of intensity followed by more subacute symptoms. The patient has never had eczema, but is subject to boils.

DR. ROBINSON then showed another case of

SYCOSIS.

The patient, a man, forty years old, has had the present eruption for the past sixteen years; the chin and cheeks as far as the sides of the nose, being involved. The case is almost similar in appearance to the one previously shown. There is a considerable amount of atrophy of the hair-follicles of both cheeks.

DR. TAYLOR said that it was within the bounds of reason that the lesion in both of these cases was one of sycosis. He knew that long-continued inflammation would be followed by atrophy; he presumed that the diagnosis was correct, although he must say that the appearances in the first case were strikingly suggestive of lupus.

DR. PIFFARD said that he was not prepared to express an opinion in regard to the first case. He thought that the second case was what was called a sycosis, an eczema with involvement of the hair-follicles.

DR. ALEXANDER, at first sight, thought that the lesion in the first patient was more like a lupus. Both cases, however, bore a great resemblance to chronic erythematous eczema. He was not accustomed to recognize sycosis, except in the parasitic form. He would say that both the lesions were erythematous eczemas, with accompanying pustular eczema around the hair-follicles.

DR. ROBINSON said that he showed both cases on account of the similarity in the appearance of the skin, *viz.*, a parenchymatous inflammation in contradistinction to a catarrhal inflammation, as seen in ordinary eczema. These cases correspond more nearly to a pustular eczema. As to the question of name, there is evidence of a parenchymatous inflammation in a chronic form, all the hair-follicles not being destroyed, and this is sufficient to keep up an inflammation. The disease originates as a peri-follicular inflammation, which finally passes into the chronic parenchymatous form. Where areas of purulent inflammation exist, there is a destruction of normal tissue, and a consequent formation of cicatricial tissue. He thought that so small a loss of tissue, as seen in the second case

which had lasted sixteen years, was of very rare occurrence in ordinary eczema. There is a condition called follicular eczema, and he now had a case under observation in which the eruption covered the legs, thighs, scrotum, and umbilicus: there was no elevation, nor pustules, only vesicles; on the thigh there were patches the size of the thumb; on the scrotum and umbilicus a chronic eczema existed, while on the legs there was a follicular inflammation.

DR. ALEXANDER asked if there were apt to be a destruction of tissue and a striated appearance of the chin as noticed in the second case.

DR. ROBINSON said that in cases which had lasted a long time there would be atrophy of the tissues, and that these striæ would correspond to the areas of distribution of the hairs.

DR. ROBINSON then exhibited a case of

TROPHIC LESIONS OF THE SKIN FOLLOWING CEREBRAL HEMORRHAGE.

Rosanna N., aged thirty-three years. Married. Has two children, the older seven years, the younger four, both living and healthy. She has had no miscarriages.

Never had any eruption on the body previous to an attack of paralysis. Had paralysis of the left arm and leg, the eyes were turned crossways, no paralysis of the muscles of the face. She was more or less insensible for two days.

The eruption appeared two days afterward, like a "cold" eruption, with spots on the left ala of the nose, front of the ear, temple, and on the scalp, all being situated to the left of the median line; no eruption on the right side of the face.

At the present time (July 14), the left ala of the nose is almost destroyed, at the apex it has not extended quite to the median line. The base of the wound is red, non-ulcerating, easily bleeding, the margin is not elevated or indurated, there is no surrounding inflamed areola and no tubercles or cicatrices.

On the side of the face directly in front of the ear are two pea-sized spots of similar character, but there is only slight loss of tissue.

On the scalp there are six isolated spots, pea to bean sized, with the same characters.

All these spots are on the left side and the eruption extends exactly to the median line.

A few cicatrices, the result of previous necrosed spots, are to be observed in the same regions. The age of an individual lesion varies. All appear suddenly and present the character of an acute serous inflammation with rapid destruction of tissue.

DR. ALEXANDER said that the lesion looked very much like those cases which had been described under the name of eczematiform syphilis, examples of which he had occasionally seen. He thought that the lesions were due to syphilis and that they occurred on one side because of the cerebral apoplexy.

DR. SHERWELL did not think that the affection was produced by syphilis.

DR. TAYLOR said that he did not believe that the lesion was caused by syphilis, because in this case there was first an inflammatory condition followed by a necrosis of the tissues, whereas in syphilis there was round-cell infiltration with subsequent breaking down of the tissues.

DR. ROBINSON said the individual lesions disappeared without treatment and showed some cicatrices behind the ear, the site of a former eruption. He believed it to be an acute inflammation of some kind.

DR. ALEXANDER then gave a brief resumé of a case of

CHRONIC ERYTHEMATOUS ECZEMA COMPLICATED BY CHRONIC NASAL CATARRH.

The patient, a young man, about eighteen years old, had a chronic erythematous and moist eczema situated mainly around the mouth, on the face, and neck as far as the clavicle. He also had cleft palate and chronic nasal catarrh. The eczema

was worst on the upper lip, gradually shading off into the surrounding tissues. There was but slight benefit under ordinary treatment. He was taken to a throat specialist, as there was an impediment in his breathing, being unable to breathe through his nose. Two masses were found and removed from the region of the middle turbinated bones by means of a snare, the mucous membrane was not treated. Since then the eczema has disappeared, although slight nasal catarrh remains. He believed that this was a clear case of eczema from reflex causes and that the same diseased condition existed in the nose as on the face.

DR. PIFFARD asked the following question :

SHOULD A PERSON AFFECTED WITH PSORIASIS MARRY?

He said that he had a patient suffering from a moderate psoriasis who asked him his opinion as to the propriety of marrying. Dr. Piffard said that he would like to have an expression of opinion, from the members of the Society, on the subject.

DR. TAYLOR said that he had seen many cases in which psoriatic patients had perfectly healthy children. In giving an opinion, he would be influenced by the length of time the eruption had existed, as well as its activity. If the question were propounded to him, he would say that if the patient suffered continuously from the disease, or if the attacks were severe, he would advise the patient not to get married, but if the attacks were ephemeral, he did not see any objection to marriage. In his mind there was no question as to the heredity of psoriasis, but it was generally in inveterate cases of long standing.

DR. SHERWELL could see no reason why a patient thus affected should not get married. He looked upon psoriatic patients as among the strongest persons. He had seen only one unhealthy patient, among several hundreds, and he had fibroid phthisis. In fact, he believed that the occurrence of psoriasis was an indication of health.

DR. ROBINSON would certainly advise psoriatic patients not to get married unless there was some other good reason aside from the question of health. He said that psoriatic persons were often unhealthy, and cited a case of a patient with psoriasis in whose immediate family two persons died of phthisis and another had scrofuloderma.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

RED CHROMIDROSIS, ITS PARASITE—LOCAL ASPHYXIA OF THE EXTREMITIES AND ATHEROMA—MYXEDEMA—ACNE OR FOLLICULITIS DECALVANS—TREATMENT OF ALOPECIA—ERADICATION OF SYPHILIS—CHANCRES OF THE TONSIL—EXTRA-GENITAL CHANCRES—INTERSTITIAL KERATITIS AND CHRONIC IRITIS OF LATE HEREDITARY SYPHILIS—CHRONIC MENINGITIS OF HEREDITARY SYPHILIS.

Red Chromidrosis, its Parasite.—Several months ago, there was a discussion on red chromidrosis by the Paris Academy of Medicine, in connection with a patient presented by Dr. Bergeron who was affected with this malady. Le Roy de Méricourt has recalled the struggle he was compelled to sustain from 1857 to 1864, in order to force the admission of the reality of this curious phenomenon. While isolated cases of chromidrosis had already been published, and the observations of James Younge (1709), of Lecat, of Billard, and of certain Irish physicians had furnished probatory evidence, yet it must be recognized that it was especially the researches of Le Roy de Méricourt which directed attention to

colored sweats, and after an active opposition forced the entrance of chromidrosis into the nosological category.

The patient of Dr. Bergeron was a young school-boy, twelve years of age, who presented in the submaxillary region and right side of the neck a transudation of red-colored material, the tint particularly vivid at the level of the prominence of the sterno-cleido-mastoid muscle. The affected points did not form distinctly limited patches, but were disposed in irregular trains; the white shirt was deeply colored in red. Le Roy de Méricourt, in examining the affected parts with a magnifying glass, distinctly saw reddish grains engaged between the lamina of the epidermis; under the microscope he perceived that the epidermic lamellæ were charged with fine rosy granulations; the next day he found towards the periphery quite a large number of irregular corpuscles colored in blue, quite similar to those described long ago in chromidrosis.

This question has been taken up by Drs. Balzer and Barthelemy, who have published an interesting article on colored sweats in the *Annales de Dermatol. et Syphilig.* (June, 1884). Their investigations have been confined to red chromidrosis of the axillæ. They report the case of a man, aged thirty-four years, who, after an attack of typhoid fever, noticed that his perspiration, which had always been very abundant and odorous, presented in the axillæ, but nowhere else, a marked reddish tint, leaving upon his shirt an extensive patch of the same color. With the appearance of the colored sweat, the hairs of the axillæ, normally brown, gradually took on a reddish tint. They became rough, breaking easily, lost their lustre and suppleness, and presented a moniliform aspect. They resembled in color the stains on the shirt, which continued notwithstanding the daily use of lotions of soda soap, followed by applications of eau de cologne. To modify this abnormal secretion, alkaline baths, sulphur baths, lavender water, solution of sublimate (1 to 1,000); borax (1 to 8); chloral (1 to 30); salicylic, thymic, and phenic acids (1 to 20) were tried in vain. Aromatic vinegar and chloroform gave a certain amelioration; ether was found the most efficacious; by its employment the chromidrosis was suppressed for a while, although it reappeared in a short time. In carefully examining the hairs of this patient, and those of several other persons subject to red or yellow sweat, the authors were able to verify the greater number of the conclusions already formulated in memoirs by Ebberts and especially by Babes (*V. Journal de l'Anatomie et de la Physiologie*, No. 1, 1884).

Under a feeble power, the hairs are seen covered with yellowish or reddish masses, sometimes separated from each other by intervals at the level of which the hair is bare, hence the moniliform aspect which it presents. The yellowish or reddish masses are, as Ebberts and Babes have demonstrated, crossed with striations which converge towards the hair, and under a high power it is easy to be seen that these striations are constituted by round or elliptic chains of micrococci presenting a yellowish, reddish, or brownish coloration; these micrococci are embedded in an amorphous or homogeneous substance, which is none other than their glair and which is likewise colored.

The microbes are not confined to the hairs; when scrapings of the epidermis are examined they are found in considerable quantity, likewise agglutinated by an amorphous substance, but not all colored. There may be found in the axillæ numerous other microbes, besides those of red chromidrosis. It is only necessary to examine several persons in order to be convinced of the frequency of parasitic masses appended to the hairs in the axillæ. Red sweat is

ordinarily met with in feeble individuals, the lymphatic, the arthritic, and among convalescents.

Babes, basing his opinion upon the existence of a parasite, admits the possibility of the transmission of red sweat by contagion. Drs. Balzer and Barthelemy think that there is a form of parasitism which occurs as a transitory or permanent condition in a large number of individuals subject to profuse perspiration, and in whom masses of microbes, generally non-chromatic, sometimes chromatic, may develop. It would be quite interesting to pursue further researches in this direction, to ascertain if the colored micrococci we have just mentioned really constitute a well-defined parasite; if there happens to the perspiration something analogous to what passes in the case of red snow, and finally to discover the secret of the appearances and disappearances, so bizarre of this phenomenon, at present inexplicable.

Local Asphyxia of the Extremities and Atheroma.—Dr. Bouveret has published in the *Lyon Medical*, June 8, 1884, an interesting case of local asphyxie of the extremities (*Maladie de Raynaud*) occurring in a woman, aged sixty-eight years, who lived in a village of Dunhes where intermittent fevers are endemic. She had at different periods of her life several attacks of marsh fever. In 1883, during the month of January, she perceived that the middle finger of her right hand had become cold, violaceous, and almost insensible. The other fingers of her right hand and those of the left hand then became affected, and the disease soon invaded the dorsal surface and palms of the hands. Sometimes also small livid patches showed themselves on the lower portion of the forearm. At its début, the asphyxia only occurred when the patient experienced a very decided impression of cold, but little by little it began to develop more readily so that the woman had to give up washing the dishes and the linen. Finally the feet were attacked. The patient had always by her side warm water in which to dip her fingers and toes when she experienced the least pain. The intensity of the cyanotic coloration varied according to the degree of cold, from a black to a livid tint with yellowish spots. Upon the black parts the anæsthesia was complete, upon those which were only livid the sensibility was enfeebled. This then would have been a typical case of the local asphyxia of the extremities described by Raynaud, if the patient had not also presented another lesion—an arterial atheroma so pronounced that the superficial arteries were plainly perceived to be hard and sinuous. The pathogenesis of the asphyxic accidents would appear to be in this case quite complex. The arteries of the limbs being atheromatous, the circulation in the extremities being already inactive, the least spasm of the small vessels sufficed to determine the appearance of morbid phenomena. It should not be forgotten that the woman had already had several attacks of intermittent fever, and that Messrs. Verneuil and Petit, in a recent memoir in the *Revue de Chirurgie*, have described a local asphyxia and symmetrical gangrene of the extremities of palustrian origin.

Myxœdema.—I shall simply call your attention to a case of myxœdema described by M. Hartmann in *La France Médicale*, Nos. 71 and 72, 1884. It treats of a woman, aged thirty-six years, who had never left Paris and had never been exposed to the exciting causes of the cachexia; she had never lived in insalubrious lodgings, and she had always had a sufficient alimentation. The disease began several months after an attack of erysipelas of the face, and developed with considerable rapidity.

Alopecia.—I should have liked to send you a resumé of the interesting and

highly practical lectures which Lailler delivered during the past summer at the St. Louis Hospital, upon the treatment of the tinea; unfortunately they have not all yet been published. One of them, upon alopecia, reported by Chevallereau, has appeared in the *France Médicale*; it contains several new ideas. The eminent dermatologist thus speaks of the diagnosis of the tinea pelade, a very rare affection, but little known, to which he has given the name of *acne decalvans*, and which develops during its course a definite calvities. In this form of acne, he says, there are ordinarily pustules and scales at the base of the hairs, there is death and loss of the hair; then after the cure of the acne element, there persists a cicatricial depression—a sort of crackled aspect of the derma—the patches present, finally, a more seborrhœic appearance. I myself have just seen a patient who was attacked more than a year ago with an alopecia of this particular form, which several physicians had already diagnosticated as an alopecia. In fact, at first glance it looked like an alopecia in patches, especially marked towards the vertex, at the level of which the integument appeared white, smooth, ivory like, altogether like a true alopecia; no seborrhœa, no scales, no crusts upon any portion of the hairy scalp. In examining it with more care, I discovered in two or three points, where the hairs still remained, a light rosy erythematous tint, a little more marked around each hair. The hairs which were surrounded by the erythematous areola were not at all adherent, the least traction sufficed to detach them, and it is certain that they would have soon spontaneously fallen out; on the contrary, the adjoining hairs around which the derma had not the red coloration were still perfectly solid. The condition might have been regarded as an erythematous lupus of the hairy scalp, but the lesion had not the circumscription, the aspect, the distinct appearance of this disease; the alopeciac parts did not present the least trace of a cicatrix; there were neither scales nor crusts. It was evidently produced by a sort of slow inflammatory process acting especially upon the hair-follicles, and resulting finally in complete, total and definitive atrophy of the follicle, and an irremediable alopecia. It was then, if the term be preferred, an acne or better a folliculitis decalvans, for there was not an actual papular and pustular acne, distinctly and frankly inflammatory. On the other hand, we should not confound cases of this kind with ordinary alopecias, in which we may always hope, at least in the earlier months of the disease, to obtain a complete cure.

To hasten the cure, which often takes place spontaneously, especially in the achromatic variety, more rarely in the other variety, Dr. Lailler advises that daily frictions be made with a flannel dipped in one of the following mixtures: alcohol, 60%, 100 grammes; essence of turpentine, 20 grammes; ammonia, 5 grammes; or alcohol at 90%, 100 grammes; sulphate of quinine, 1 gramme; essence of bergamot, 10 grammes; essence of wintergreen, 2 grammes.

It is also necessary, from time to time, to shave the scalp, and give, if need be, internal treatment to the patient.

Eradication of Syphilis.—The celebrated syphilograph of Lyon, Dr. Diday, in May last, gave a lecture at the Charity Hospital in Paris, upon the eradication of syphilis. Like all the other productions of this author, this savant contribution to the study of the excision of syphilitic chancre sparkles with so much of *esprit* and *verve* that a mere analysis of it must appear dull and flat. By a most brilliant argumentation Dr. Diday has demonstrated that if excision of the indurated chancre fails in many cases to arrest the evolution of syphilis, in some cases, nevertheless, it has undoubtedly prevented the explosion of secondary

accidents. He counsels that excision should be practised in as large a number of cases as possible when the ganglia are not yet engorged.

Chancres of the Tonsil.—Paul Legendre has published, in the *Archives Générales de Médecine* (Jan. and Feb., 1884) an excellent article upon syphilitic chancres of the tonsil. He there shows that this localization of the initial lesion is far from being so rare as is generally supposed. Pollet is one of the first syphilographers who published examples of this nature, then Diday in his study of chancre of the tonsil (1861-1862) mentions 8 cases; M. Legendre, in his article reports 13 cases; 3 of Dr. Helat, 1 of Dr. Barthélemy, 1 of Dr. Morel Lavaller, 1 of Dr. G. Hue, 1 of Dr. Merkle, and 1 of Dr. Spillmann. Five had not been published, and of these five cases two came under the author's observation; one was a case of Dr. Lannois, and two were my own. The interesting feature of most of these cases is the errors of diagnosis which chancre of the tonsil occasions. The first case of Dr. Legendre was mistaken for diphtheritic angina, for which the patient was conscientiously treated during several days; there was a slight fever, an extreme fatigue, an indefinable malaise, a generally bad condition. The affected tonsil was enlarged, covered with a thick coating, grayish and quite adherent, the submaxillary and likewise the cervical ganglia were much engorged. In one of my cases, the patient had been supposed to be suffering from a gangrenous angina, the tonsil was much tumefied, and presented on its superior surface a blackish patch of sphacelic aspect, a centimetre in diameter, with clearly defined borders, and separated from the surrounding tissues by a sort of furrow of elimination filled with pus. The submaxillary adenitis was enormous and slightly painful. The true diagnosis was not made until a month later, after the appearance of secondary symptoms. In another case, still unpublished, which I have this moment found among my notes, the patient was treated for more than a month for a chronic angina. In the case of Merkle the patient, aged sixty-four years, presented behind the ascending ramus of the left inferior maxilla a large, hard, lobulated, painless tumefaction. An examination of the throat brought to view a deep ulceration, irregular in outline, with pultaceous floor, occupying the left tonsil and having apparently completely destroyed it. The surrounding tissues were indurated, and gave to the finger the sensation of a ligneous consistence. Dr. Verneuil did not hesitate to pronounce it an epithelioma of the tonsil. In Lannois' case, the chancre was mistaken for an ulcerated gumma; the tonsil presented on its entire surface an ulceration which penetrated to the centre of the organ. Reddish granulations occupied its base, and at certain points grayish lamina of necrosed tissue were detached.

It will be perceived that the errors in diagnosis are quite frequent in chancre of the tonsil, and that these errors are, to a certain extent, justified by the variability in the objective characters effected by the primary syphilitic ulcerations in this region. M. Legendre has not thought it necessary to describe the erosive, ulcerous, diphtheroid, gangrenous varieties of chancre of the tonsil, but he has justly observed that these are deceptive aspects which the accident may assume and which should not mislead the physician. In all such cases induration of the neighboring parts should be carefully examined—induration is always present, submaxillary adenopathy is likewise constant, indolent, unilateral, and very often constituted by one enormous ganglion, which is very hard, almost immobile, and surrounded by several smaller ganglia. These characteristics will permit a diagnosis in a majority of cases. M. Legendre terminates this remarkable study of chancre of tonsil with the remark that the

cause of this special localization of the primitive accident of syphilis is not always due to depraved practices. Among the thirteen patients whose history he reports in his memoir, were seven men and only six women. One of these six women had been infected by sucking the nursing bottle of her syphilitic child; another in kissing a child which had mucous patches of the lips. He is thus rather disposed to admit that inoculation of the tonsil is most often affected by the intermediary of contaminated saliva, and not by direct contact.

Extra-genital Chancres.—Drs. Lavergne and Perrin have published in the *Annales de Dermatologie et de Syphiligraphie* (June and July, 1884) a report of the extra-genital chancres which they have observed in 1883 at the St. Louis Hospital, in the service of Prof. Fournier. In one year and in one service of this wonderful hospital, which has six services equally important, and the clinical richness of which can only be appreciated by a long attendance, these conscientious observers have collected twenty-seven cases of extra-genital chancres, which may be divided as follows: Lips, 10; eye and eyelids, 5; cheek, 2; anus, 2; nose, ear, neck, arm, finger, bosom, leg, thigh, each 1; total 27. As an interesting feature we note that among the twenty-seven patients, twenty-one were men, and only six women; that five times the contagion had followed the bite of a patient affected with buccal syphilides. In sixteen out of the twenty-seven cases, the mode of contagion was not discovered. This interesting work terminates with a monograph upon chancres of the eye.

Interstitial Keratitis and Chronic Iritis of Late Hereditary Syphilis.—Before the remarkable lectures of Prof. Fournier upon hereditary syphilis, of which I have given you a resumé, French physicians did not assign to syphilitic heredity the important influence in the multiple accidents of childhood and adolescence which had been until lately attributed to scrofula. Now, however, we are more familiar with these questions, and the numerous publications upon this subject show that they are the order of the day. Dr. Abadie has declared before the French Ophthalmological Society that he has adopted almost entirely the views of Hutchinson upon the syphilitic nature of parenchymatous keratitis. He includes in hereditary syphilis certain forms of iritis presenting *d'emblée* the chronic form, and accompanied with lesions of the fundus of the eye due to the same specific cause. This affection is met with, he says, among patients of from twelve to twenty years of age, and is curable by anti-syphilitic treatment. In these cases, it may happen that mercurial preparations and iodide of potassium fail; we should not be discouraged, but vary our treatment. Sometimes the syrup of Gibert is inefficacious, when mercurial frictions, subcutaneous injections of the bichloride, the combination of large doses of iodide with feeble doses of the sublimate will succeed. Sometimes even the abrupt suspension of treatment is followed by a marked amelioration of the symptoms, which only commences when all medication is discontinued, especially if this medication has been rigorously conducted for some time. This communication of Dr. Abadie did not fail to excite the protestation of Prof. Panas, who has always been opposed to the ideas of Hutchinson.

Dr. Parinaud, in response to the eminent Professor, declares that an examination of twenty-three cases of parenchymatous keratitis observed by him shows that this affection is especially apt to occur in children who were conceived when the syphilis of the parents was already old, and that it was consequently an expression of an attenuated syphilis of the parents. It is probably not a lesion directly syphilitic, but a lesion of degeneration due to the organic *déchéance* created by hereditary syphilis—that is, an indirect product of syphilis.

Chronic Meningitis of Hereditary Syphilis.—In a memoir in the *Revue Mensuelle des maladies de l'enfance* (Nov., 1883) Dr. Dreyfous has touched upon another obscure point of hereditary syphilis—the establishment of a direct line between certain cases of infantile chronic meningitis, heretofore attributed to tuberculosis and hereditary syphilis. It is undeniable that syphilitic meningitis exists; hereditary cerebral syphilis likewise exists; modern researchers, particularly those of Prof. Fournier, have abundantly proven this. It will be necessary, then, in the future to search with care for a history of hereditary syphilis in children who present symptoms of meningitis, and no matter how few vestiges of the disease exist, however doubtful the cases may be, institute anti-syphilitic treatment, this constitutes the patient's sole chance of safety, and should not be neglected.

Who knows, indeed, whether certain cases of tubercular meningitis with remissions and of prolonged evolution, which all the classic authors cite, were not pure and simple cases of hereditary cerebral and meningeal syphilis?

L. BROcq.

PARIS, November, 1884.

Selections.

THE SYPHILOCOCCUS.

THE notion that contagious diseases are propagated through the agency of microscopic organisms was entertained by many eminent authorities as far back as the beginning of the present century. With regard to syphilis, in particular, it was the belief of Cullerier that peculiar animalcules existed in the lesions of that complaint. In 1837, a parasite was detected by Donn , in the secretions of chancres and buboes, but he concluded that its presence was entirely accidental, and that it bore no specific relation to the malady. It appears, in fact, to have been nothing else than the *Vibrio lineola* already described by M ller. The earliest reliable data in this connection were those obtained by Hellier, who, in 1869, discovered in the blood of syphilitic subjects large numbers of micrococci bearing a marked resemblance, in their action upon the red corpuscles, to the micrococci of scarlatina. Klotzsch, in the same year, detected spores in syphilitic blood and in the cuticular d bris of syphilitic psoriasis. Lorstorfer, in 1872, discovered in the blood of infected subjects what he believed to be the characteristic corpuscles of syphilis—round, shining objects, which gradually increased in size during several days, and finished by developing a “vacuole” of considerable dimensions. These results were variously estimated by the Vienna dermatologists; but the question as to the origin of syphilis remained still undecided. Professor Cornil, in his hospital lectures during the year 1878, makes a passing allusion to the parasitical theory, as plausible and even fascinating in itself, but as wholly unconfirmed by facts. In the same year Klebs made known the results of his researches, by which a new era was opened in the history of our subject, since, unlike the foregoing, they were based, for the most part, upon exact experiments and accurate observations. He presents the following as his general conclusions: “1. Syphilis may be transferred from man to animals by inoculation. 2. Human syphilitic products contain a low grade of specific organisms—micrococci and rods (Figs. 1, 2, 3)—which, cultivated independently, are characterized by the production of peculiar forms, the *h licomanades*

(Fig. 4). 3. By inoculating suitable animals with these latter, the human variety of syphilis is produced, as well as that which belongs to the inferior species." The successful experiments in this instance were performed upon two monkeys, one of which was inoculated (in 1875) with a culture-fluid ; the other



FIG. 1.

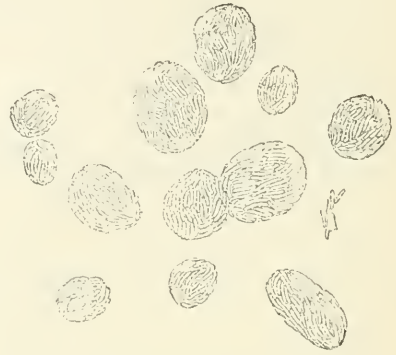


FIG. 2.

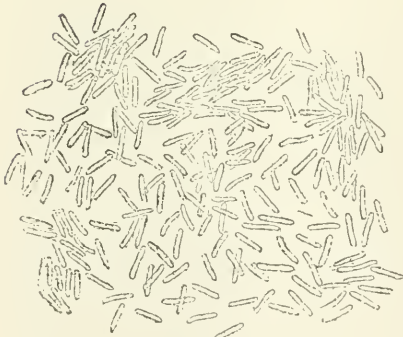


FIG. 3.



FIG. 4.

(in 1878) with excised portions of an indurated chancre. The former became affected with ulcers resembling syphilitic sores, in the buccal cavity and on the gums ; the latter developed a papular eruption. No initial symptoms were observed in either, but the autopsies disclosed lesions which were taken for premature syphilomata.

In 1878, also, E. Cutter, of Boston, announced his discovery of mycelium in syphilitic chancres. He stated, moreover, that in syphilitic blood the white corpuscles were increased in size, and that it also contained bacteria and myceli-

um-filaments. Among the other American investigators in this department may be mentioned Bermann, of Baltimore, who attributes the syphilitic infection to spores and bacteria of a specific nature. The micrococci he found chiefly in the lymphatics; the bacteria in the arteries only. But these organisms resembled those described by Klebs.

Passing now to the German authorities, we find that, in 1881, Aufrecht, of Magdebourg, claimed to have detected in syphilitic papules a micrococcus of large size, occurring generally in couples, more rarely linked together by threes. It was strongly brought out by coloring with fuchsin. Ulcerated mucous patches, as also those which had been subjected to treatment, presented only a few of them. Oblaszow, on the other hand, discovered colonies of micrococci in lymphatic glandular swellings attendant upon indurated chancres; also, in similar enlargements produced by chancroids, but here they were less numerous.

In 1882 the microbe of syphilis was the object of investigation in many different quarters. First in order came Birch-Hirschfeld, with the assertion that micro-organisms exist in all *gummy tumors* (excepting cicatrized gummata), and that they abound especially on the borders of the granulating tissue. He found them in *mucous patches*, in *indurated chancres*, and in a single case of *papulous roseola*. They were formed by the union of several cocci, usually in the shape of a long oval, which never included more than four or five individuals. Precisely similar elements were shortly afterwards described by Peschel.

On September 5, 1882, Martineau made a report to the Académie de Médecine concerning the *syphilitic bacteria* discovered by himself in conjunction with Hamonic. He had inoculated a pig by means of a culture-fluid in which an indurated chancre had been steeped for twenty-four hours. The culture-fluid contained two different kinds of bacteria and a few micrococci. Next day bacteria were found in the animal's blood. One month later, a "papulo-squamous syphilide" was developed. In the blood of another pig (four weeks old) bacteria were discovered four days after inoculation as above, followed likewise on the fourteenth day by a squamous syphilide. The bacteria in both these cases, when cultivated and inoculated into other animals, gave only negative results. These experiments were severely criticised by Koch, and in fact their significance is highly questionable, and the technical processes employed by no means beyond suspicion. The following, however, is of a more convincing nature:

On November 17 of the same year, a monkey was inoculated by Martineau with the secretion from an indurated chancre. Twenty-eight days later, two chancres, having all the typical characteristics of an indurated sore, made their appearance upon the animal's prepuce. These were succeeded by unequivocal secondary symptoms. In September, 1883, an ulcerated syphilide, which persisted for three weeks, had formed upon the velum palati. October 21, epileptiform paroxysms occurred, lasting four or five minutes each. December 3, an hypertrophic papulous syphilide was noticed on the right side of the scrotum, June 18, in the following year, another papulous syphilide appeared on the palate, remaining for fourteen days. After this, the monkey began to recover, and ultimately was restored to perfect health.

With the exception of the foregoing, all experiments on animals of different species—rabbits, dogs, pigs, goats, monkeys, etc.—by whomsoever undertaken, and though conducted with the utmost accuracy and skill, have proved entirely barren of decisive results, so far as the reproduction of syphilis is concerned. The writer's own microscopical examinations of chancrous secretions and frag-

ments which had been used for inoculations, revealed the presence of the microbe described by Klebs.

Morison has succeeded in proving the presence of bacteria in the diseased secretions of no fewer than fifteen variously affected syphilitic patients; in fact, he has never failed in a single instance. The matter from soft chancres he found to contain a distinct variety of bacteria, larger, more slender, and, except in size, resembling the bacteria of charbon. As a general rule, the blood of persons in health, or laboring under eczema pemphiginosa, yielded no such products, although, more recently, Morison has detected the same organisms in the ulcer of eczema impetiginosa, of acne, etc.

Neisser has published his belief in the parasitical origin of syphilis, and has advanced an ingenious theory in explanation of the course of the disease as related to the gradual development of its germs.

Barduzzi has lately observed, in the serum of a syphilitic pemphigus-bulla, numerous micrococci, as also bacteria formed by a series of small cells, each of which resembled a minute micrococcus surrounded by a gelatinous areola (Fig. 5). As shown by the accompanying illustration, objects grouped in this fashion scarcely deserve the name of bacteria.



FIG. 5.

De Tornery and Marcus have been experimenting in Vulpian's laboratory on the persistence of the microbe of syphilis. They give the following summary of the results so far arrived at: In syphilitic products and artificial cultivations, societies of cocci are observed, easily colored by Gram's method. The rods originally observed by Birch-Hirschfeld and Martineau are present in very small numbers; they disappear after the third cultivation, and are killed by a mixture of acid and alcohol at 3 per 100. M. and D. believe that these rods are due to septicæmia, or result from the juxtaposition of two or three cocci. The cocci are easily cultivated in beef-broth, to which is added gelatin and an alkali.

These investigations are decidedly interesting, and were more scientifically conducted than most of those which we have previously noticed. The micrococcus in this case would seem to be really the contagious agent in syphilis. We do not know whether De Tornery and Marcus have tested the virtues of their culture-fluid by inoculations, either of men or animals.

It should be mentioned before closing that Diday is an advocate of the parasitical theory of syphilis, and that Leloir has been experimenting in this direction for some years past.

It seems reasonable to infer from the statements which we have reviewed, 1st, that syphilis is a parasitical malady. 2d, that its microbe is probably a micrococcus, whose nature has still to be ascertained. 3d, That inoculations with the direct products of syphilis have been negative, or at least doubtful in their results, excepting in the case of Martineau's monkey, which is still a solitary instance. 4th, That inoculations with culture-fluids have been entirely unsuccessful, owing, perhaps, in part at least, to the defective methods generally pursued.—P. BRICON, *Le Progrès Médical*, Oct. 11, 1884.

NATURE OF LUPUS VULGARIS.

Two widely-differing opinions prevail at present among dermatologists respecting the essential character of the affection known as lupus vulgaris, tubercular

lupus, or the lupus of Willan. By some it is regarded as a species of cutaneous tuberculosis, confined (at least at its outset) to particular localities, and of primary origin; while others contradict this view, maintaining either that lupus consists in a peculiar neoplasm, entirely unrelated to tubercle, or that it is a distinct inflammatory affection of the skin.

In weighing the arguments adduced on either side, we must compare the leading features of the maladies in question—lupus and tuberculosis—as traceable in their clinical histories, their pathological anatomy, the results of experimental inoculations, and finally in the descriptions of their specific micro-organisms.

Clinical comparison. The symptoms of lupus vulgaris certainly differ from those of cutaneous tuberculosis properly so-called, as the latter have been delineated by Bazin, Vidal, and other authorities. But it should be remembered that two affections of the same essential nature do not uniformly exhibit the same symptoms. Moreover, if lupus be regarded as a *primary* tuberculosis of the skin, its external manifestations must necessarily differ from those of a tuberculosis *secondarily* affecting the same organ in an individual already under the full constitutional influence of the disease.

The relations between lupus and the strumous diathesis have long been a subject of debate, but it is only recently that clinical and statistical inquiries have been earnestly turned in this direction. The investigations of Fournier, Quinquaud, Lailler, and especially of Besnier, appear to prove that lupus subjects are more liable than others to contract phthisis, but that the complaint in their case frequently evades detection, because remaining for a considerable period localized, latent, and without effect on the general constitution, and because it is often manifested only in slight and transient attacks occurring at long intervals. In this paroxysmal form, phthisis is not of rare occurrence among lupus-patients. They are also rapidly carried off, in many instances, by an acute general miliary tuberculosis. At the St. Louis Hospital this termination has been found to occur in about one case out of seven. Minute and careful researches are still requisite for the settlement of this question. Its statistical solution is particularly difficult because, if lupus is a local tuberculosis, a longer or shorter period, sometimes a very long one, must necessarily elapse between the appearance of this local tuberculosis and the secondary constitutional infection. Lupus-patients, therefore, should not merely be thoroughly examined at the outbreak of their disease—they must be followed up perseveringly to the end, and this is not always an easy thing to do.

It has been asserted that lupus never affects the osseous system, but this rule is certainly not without its exceptions. I have the notes of a case occurring in the service of Dr. Lailler, where lupus of the face and throat undoubtedly extended its ravages to the bones of the nose, upper jaw and palate. It is, I believe, the first authentic instance of the kind on record. The patient died of acute general miliary tuberculosis.

The *pathological anatomy* of lupus, as unfolded by Friedländer and Koster, has demonstrated the absolute morphological identity of this disease with tuberculosis—an identity which is still more clearly shown by the fact that sclerous lupus, which bears to lupus the same relation that fibrous tuberculosis of the lung does to ordinary tuberculosis of that organ, exhibits precisely the same structure as fibrous tubercle.

Subcutaneous *inoculations* of animals with lupus-matter have for the most part been unsuccessful in the production of tuberculosis. By injecting the virus,

however (under strict precautions), beneath the peritoneum or within the anterior chamber of the eye, I have been able to produce a general miliary tuberculosis—the tubercles containing bacilli, and giving rise to tuberculosis by successive inoculations—in about twenty-five per cent of the cobayes and rabbits operated on. Shortly afterwards similar results were attained by Koch. My own experiments have since been repeated on a larger scale, and with commensurate success.

I next proceeded to inquire why the virus of lupus inoculated into the peritoneum and anterior chamber of the eye, should so frequently cause tuberculosis, while, if inserted in the usual manner beneath the skin, it seems unable to do so. An accident furnished me with what I believe to be the true explanation. In each of two cobayes—who failed to respond to peritoneal inoculation—the skin only having been sewed up, the morsel of lupus-matter had escaped from the cavity of the abdomen and lodged just under the skin between the incised muscles of the latter, along with a bit of ruptured epiploon with which it remained in close contact. Two months after the healing of the wound (which was completed in eight days) a flattened swelling about the size of a penny-piece arose at the inoculated point. This tumor finally ulcerated at the centre, the sore looking very like a superficially ulcerated scrofulous gumma of the integument. Sections of the same bore a striking histological resemblance to lupus-sections.

Since then, I have succeeded twice out of seven times in my endeavors to reproduce the above phenomenon by joining the bit of lupus-matter introduced under the skin to a shred of ruptured epiploon, for the purpose of affording it nourishment. In the successful cases the animals after death presented no other tubercular lesions than the swelling just described. All the facts, then, seem to prove that, by inoculating with lupus-matter under certain conditions, we can produce, at our pleasure, either a general or a local tuberculosis—that is, the latter will remain localized for a certain time, at least.

Micro-organisms of lupus. The joint investigations of Professor Corlil and myself, so far as they have yet proceeded, have not resulted in the discovery of any form of microbe belonging to this affection. Koch, however, has been more fortunate. He has detected bacilli in seven cases of lupus, has cultivated them, and has produced unmistakable general tuberculosis by inoculation with the culture-fluid. Should these results be confirmed by future researches, the question will be definitely settled.

Nevertheless, confining my reasoning to the facts which I have myself observed, either alone or in association with my colleague, I cannot avoid connecting this absence of baccilli in the cases we have studied, with the variable success of our inoculations. In the cases which “took,” the tubercles—contrary to what occurs in genuine tuberculosis—were comparatively slow in making their appearance after the performance of the operation. If, then, it seems likely, after what has been said, that lupus is a local tuberculosis, it must still be regarded as tuberculosis in a state of attenuation. May it not be that the negative peculiarities (so to speak) of lupus—its lack of bacilli, and the infrequency of its successful inoculations—are owing simply to its protracted duration, in which it resembles fibrous tubercle? In this latter structure we know that the bacilli of tuberculosis are very rarely found.

What, now, are we to conclude from the foregoing statements? Undeniably, clinical observations, pathological anatomy, and, above all, the results of experimentation, seem alike to testify that lupus is *frequently* a primary local tuberculosis of the skin or mucous membranes. But is this *invariably* the case? Is not

the affection sometimes *something else*? In other words, are its distinguished clinical features so clearly and accurately defined as to enable us to say of lupus vulgaris—that is, of *what we actually understand by that term*—that it is *always* a primary local tuberculosis of the skin? The question scarcely admits of a decisive answer. Who can venture to deny the possibility that under the name lupus vulgaris may be included *affections essentially and specifically distinct, however alike in their objective features*? General pathology is constantly presenting us with instances in which similar effects (or, at least, effects which *seem to us* similar) are produced by widely-differing causes. Thus, without adverting to the obsolete notion of a syphilitic lupus, we see various dermatologists, such as Hutchinson and E. Wilson, Fournier and Veiel, admitting the possible occurrence of lupus as a late manifestation of hereditary syphilis—a sort of degenerate luetic product that mimics the real scrofulo-tubercular lupus. Professor Fournier has informed me of a singular case bearing upon this very point. It is that of a priest on the staff of a well-known religious establishment, whose face was attacked by a lupus about as large as the palm of the hand. It presented, with its softened, semi-transparent, “barley-sugar” tubercles, a highly characteristic form of the disease. Fournier exhibited it to his hospital-colleagues as a typical case of lupus vulgaris, and there was no hesitation about the diagnosis. Nevertheless, Fournier, in order to satisfy his conscience, prescribed some iodide of potassium internally, without any local treatment whatever. In less than five weeks the lupus was completely cured. The priest had never had syphilis—in fact, Fournier was quite convinced, on various grounds, that he was a virgin. Was this an irregular variety of pseudo-lupus proceeding from tardily developed hereditary syphilis? There is another case of the same kind in the St. Louis Hospital, at this moment.

On the other hand, the objection will certainly be interposed by some dermatologists, including Vidal, that the fact of a resemblance between true cutaneous tuberculosis and lupus vulgaris is insufficient to prove the identity of the latter with the former. And, in fact, *it is, as yet, impossible to positively affirm this identity*. Perhaps future investigations, properly conducted, will enable us to decide the question by separating the lupus of Willan into several distinct diseases—and just as likely, they may serve only to establish its unity upon an unassailable basis.—H. LELOIR, *Le Progrès Médical*, Oct. 4, 1884.

LUPUS OF THE VULVO-ANAL REGION.

THIS undoubtedly rare disease was first described as a separate affection by Huguier, in 1848. He calls it *l'esthiomène*, and divides it into several sub-varieties, which are now by general consent contracted into two, viz., the superficial or serpiginous; 2. the hypertrophic. By West reference is made to five cases, and in Duncan and West to another case. The best account of the disease in the English language which I have been able to lay my hands upon is from the pen of Dr. Isaac E. Taylor, and is contained in Vol. VI. of the “American Gynecological Transactions,” p. 199. He gives an account of seven cases.

I have, myself, met with only three examples of true lupus in this situation, all of the hypertrophic variety. Of that very unsatisfactory class of cases sometimes called lupoid ulceration of the vulva—characterized by numerous tender, ulcerated, and painful spots near the vaginal orifice, which are difficult to heal, and very liable to return again after being apparently healed—I have seen a great many more than I care for, or have obtained much credit from.

As to the nature of lupus in general, it appears to be an affection of the true skin, whether originating in the cutis, in the rete Malpighii, or in the sweat-glands, characterized by a tendency to the formation of rounded points or tubercles, by proliferation of large, round cells in a matrix of soft connective tissue (some of the cells assuming giant proportions). These tubercles, which vary in size from that of a pea to a bean, as they increase in size break down by suppuration, and leave an angry ulcer, which tends to spread and has little inclination to heal, and is extremely liable to break out afresh after it seems to have been cured. Efforts have been made to connect lupus with certain cachectic conditions, such as syphilis and scrofula. It would appear, however, that it must be looked upon as a local and not a general affection, its origin having to be sought for in some local irritation. It is urged by Huguier, in explanation of the frequency of lupus in the face and vulvo-anal region, that anatomically and physiologically, these regions have very much in common. Of the condition as affecting the vulva, no better statement can be given than the following from Huguier's memoir:

"This chronic malady, which holds a middle position between the elephantiasis of the Arabs, syphilis, cancer, and scrofula, whilst it is not essentially of this last nature, is characterized by the leaden or violet tint of the parts, their disfigurement, induration, and engorgement, their ulceration, destruction, hypertrophy, and simultaneous infiltration, in such a manner that the orifices and canals presenting themselves in the vulvo-anal region may be at the same time ulcerated, enlarged, and contracted, their furrows and cutaneous furrows and foldings more developed, thickened, and the seat of ulcerations and cicatrices more or less extended and deep, without continuous or darting pains, without directly threatening life, or even for long without inducing a marked effect upon the constitution.

I am inclined to agree with Dr. Isaac E. Taylor in believing that the deformity and disfigurement resulting from the ulcerations and cicatricial contractions of a vulvo-anal lupus are greater and more disgusting than the corresponding changes which this disease effects on the face. The destruction of tissue is indeed sometimes terrible in its extent; yet there is an extraordinary disproportion between the feelings of pain and discomfort and the amount of ulceration and swelling. The ailment, while extremely chronic in its nature, is of a purely local and non-infecting character, never involving the inguinal or other glands. The entire ano-perineal region may be eaten away, the bowel being at one time contracted by the disease, at another dissected and left hanging out like the torn sleeve of a coat. As the affection creeps over the anterior edge of the perineum its tendency is to extend a small distance into the vagina, and in this situation the hypertrophy is not nearly so marked as when it passes anteriorly so as to invade the labia. The appearance posteriorly is that of a shallow ulcer, with edges very distinctly indurated, but not overhanging. Anteriorly, the ulceration burrows deeply below the tissues, and its edges are bounded by hypertrophied polypoid-looking masses of tissue invaded by lupoid elements.

Diagnosis.—The diagnosis of this affection is of very great importance, and requires careful consideration, as it is apt to be mistaken more especially for specific disease and for epithelioma. First to distinguish it from epithelioma of the vulva.

1. Epithelioma gives rise to a more stony hardness than lupus does, and is not accompanied by the peculiar tendency to hypertrophy of the adjoining tissue.

2. Epithelioma never forms an open sore for months and even years without infecting the glands in the neighborhood or inducing secondary malignant disease in some distant organ.

3. Besides, when epithelioma does ulcerate, it does not give rise to the deeply-excavated ulcers with overhanging edges which lupus does, but to a more shallow, although angry-looking surface.

4. It is seldom that epithelioma persists long in the vulva or elsewhere without giving rise to pain, especially of a lancinating character, and this is particularly not the case with lupus.

5. The microscope may be employed in case of doubt, when the portion removed, if from epithelioma, will show the characteristic cancer cells, whilst the lupus will exhibit lupoid tissue.

6. In a case of long-continued lupus, the fact of its prolonged duration, without deeply affecting the constitution, is itself conclusive evidence against the possibility of its being any form of malignant disease. But I believe the *greatest difficulty* is to get the medical adviser to think of lupus as a possibility.

From Syphilitic Ulceration.—The history of the case ought to be carefully scrutinized, and the possibility or probability of constitutional syphilis investigated. If the result is negative, it is in favor of the non-syphilitic character of the affection. M. Huguier enters at considerable length into this distinction. One may gather, I think, from his observations, that the surrounding hypertrophy, the depth and extent of the ulcerations, and a careful estimate of the history will usually suffice to separate lupus of the vulva from specific disease of that region.

The Prognosis is on the whole good.—Of Huguier's 9 patients, 3 were cured, 2 were relieved, 2 were not relieved, and 2 died. Of West's 5 cases, 1 was cured, 2 relieved, and 1 died under chloroform, and not as a result of the disease. Of Dr. Isaac E. Taylor's 7 cases, 2 were cured, 2 relieved, 2 not relieved, and 1 died. Of my 3 cases, 1 died of exhaustion after seven and one-half years of the disease, 2 were, so far as we can at present judge, cured.

Treatment.—In the milder, or what is called serpiginous form of this affection, the treatment to be adopted is of a simple character, so far as I can judge. If such cases came before me, I would endeavor to remove it by the administration of constitutional remedies, such as Donovan's solution, the application of mild, stimulating lotions, and the free use of scarifications, as practised by Vidal in Paris, the good results of which in facial lupus I have myself witnessed. But for the hypertrophic form, or cases in which there is much and deep ulceration, I do not hesitate to state that I regard the removal of the diseased structures as a necessary preliminary to successful treatment. Care must be taken in removing the disease in the posterior part of the vagina to avoid wounding the rectum. Consequently a different method must be adopted, according to the part of the surface we are dealing with. To meet this difficulty, I remove the hypertrophied and diseased-looking hard tissue posteriorly by knife, by scissors, or by gouge, according as I find one or other instrument the most suitable. I endeavor to arrest the bleeding points by touching the surface with a Paquelin's cautery at a dull-red heat. The base of the ulceration requires also to be freely touched with the cautery. The redundant hard tissues anteriorly in the region of the labia and clitoris, I prefer to dissect off with the Paquelin cautery knife. It does its work excellently, is free from subsequent pain, and effectually arrests hemorrhage. The raw wound is then treated like a granulating healing sore, with antiseptic

and non-irritating dressings. The patient is put upon arsenic or iron, or both, or other analeptic, according as such appears to be indicated. But, judging from two of my own cases, I find it hard to believe that constitutional cause has much to do with the production of the disease, and consequently also that it can be greatly alleviated by constitutional treatment.—ANGUS MACDONALD, *Edin. Med. Journal*, April, 1884.

GONORRHŒAL RHEUMATISM

This is an affection which arises in the course of a gonorrhœa, not by a mere coincidence, but as a special variety of rheumatism originating solely in the first-named malady. A patient who has been once attacked by gonorrhœal rheumatism will be likely, even after being thoroughly cured, to suffer in the same way again should he contract the infectious disease a second time. This rheumatism presents some peculiar features. In the first place, it is very seldom met with in females. Moreover, it possesses a remarkable affinity for the larger joints, such as those of the knee, elbow and hip, the small articulations being only secondarily involved. It is also usually confined to a single joint. Sometimes the articular affection is accompanied by extravasation and serous effusion: sometimes it is followed by ankylosis, which, through the rapid formation of fibrinous adhesions, may become hopelessly confirmed in the course of twelve or fifteen days. But gonorrhœal rheumatism may also invade other tissues. Thus: first, a joint may appear to be affected while it is the tendinous sheaths in its vicinity that are really involved, in which case we shall have a tendinous synovitis with swelling, and effusion. Second, the muscular system may be the point attacked, as evidenced by symptoms of the cervical muscles, of the deltoid, or even of the *motores oculi*. Third the afflicted parts may be the *bursæ mucosæ* of the elbow knee and hip joints. Fourth, the sciatic nerve is not unfrequently attacked. Fifth, as was first remarked by M. Guyon, there may be œdema of the cellular tissue, with heat and pain. Sixth, the disease has been often known to seize upon several tissues at once in the same region.

Gonorrhœal rheumatism is also distinguished by the fact that it does not extend to the internal organs; the lungs and heart are never affected. It is of short duration and does not return, except after a fresh attack of gonorrhœa. A curious connection has been observed between gonorrhœal rheumatism and the urethral discharge—viz., that in some cases, though not always, where the latter is abundant, it diminishes after the appearance of the articular symptoms. This occurrence is still known by the old-fashioned designation of metastasis.

As to prognosis, the complaint in question is comparatively unimportant when involving only the tendinous sheaths—the *bursæ mucosæ*—or the muscles. But it is quite otherwise when the mischief is seated on a joint. Here the utmost vigilance is demanded, lest the process shall terminate in ankylosis. And whenever we are called upon to treat gonorrhœal rheumatism it should be our care first of all, to place and maintain the limb in the most favorable position, with a view to this unfortunate contingency. I recollect the case of a young woman who, having contracted gonorrhœa from her husband, and suffering from consequent rheumatism, had both her elbows immovably fixed in a most awkward fashion, her medical attendant failing entirely to recognize the real nature of the ailment. When summoned in his stead, I could only announce that the mischief was irreparable, except by a resort to osteoclasis or resection.

A stiff joint is one of the most frequent results of gonorrhœal rheumatism; it is

often accompanied by muscular atrophy, and lasts a long time. In such a case we should try to restore freedom of movement gently and by degrees, so as to avoid hardening and enlarging the fibrous tract. These troublesome conditions are best treated by electricity, massage, sulphur baths, and the waters of Aix.

Our general management of this disease must differ from that of ordinary rheumatism in which salicylate of soda is the sovereign remedy. Here this agent is without effect, and we have to fall back upon revulsive medication, especially blistering, repeated twice or thrice at intervals of two or three days. When there is much effusion into the cavity of a joint, we should not hesitate to puncture the latter, an excellent procedure, since it affords immediate exit to an amount of fluid which would require two or three weeks for its absorption. The operation should be performed with a flambée canula, which should be rapidly introduced, lest it carry with it septic particles from the atmosphere. The joint should then be firmly compressed, in order to prevent a return of the effusion.

Lastly, as gonorrhoeal rheumatism is attended by a speedy lowering of the constitutional forces, a judicious use of tonics is advisable, and our most reliable agent in this class is the sulphate of quinine.—TERILLON, *Gaz. des. Hôp.*, Aug. 7, 1884.

ERUPTION CAUSED BY THE EXTERNAL APPLICATION OF IODOFORM.

THE author has observed, within a brief period, seven or eight instances in which the external employment of iodoform has occasioned an erythematous affection, characterized by the formation of small vesicles, and bearing a close resemblance to acute eczema.

The applications were followed in a few hours by a deep redness of the surfaces acted on, gradually fading towards its edges, and accompanied by violent burning itching. Soon after, vesicles filled with a clear fluid made their appearance, to be converted—according to their localities, and the accidents (as scratching, friction of the clothing, etc.) which befel them—either into moist, crusty elevations, or circumscribed pustular patches of an impetiginous character. The degree of development attained by the complaint depended, of course, upon the duration of the drug-action and the frequency of its repetition. The extent of surface affected, rather than the severity of the local manifestations, appeared to be chiefly influenced by these circumstances: even a single application sufficed to evoke the morbid process in all its intensity.

The disease in question, therefore, may be defined as an acute dermatitis, or, more precisely, as a specific medicinal exanthem, in whose production a constitutional predisposition, or an inborn idiosyncrasy, is largely concerned.

The same results were found to follow, without important modification, from the use of every kind of iodoform, and whatever chemical impurities the article might contain. The mode in which it was applied—whether as a powder or an ointment, in solutions of ether or collodion—was equally a matter of indifference. It was enough for this purpose if the smallest trace of iodoform was present with the vehicle. Yet no such effects were produced, even in the most susceptible subjects, by the *internal* administration of the drug.

This iodoform-eruption may in most respects be likened to the mercurial eczema which affects some persons after inunctions with ung. cinereum or ung. precipit. alb. On the other hand, it differs essentially from those cutaneous inflammations which so frequently result from the use of carbolic acid or corro-

sive sublimate as a dressing for wounds. These latter phenomena are, for the most part, entirely local; they show no tendency to rapid peripheral extension, and, above all, no peculiar predisposition on the part of the skin is required for their production. The iodoform affection possesses no special features by which it can be recognized at once without a knowledge of its exciting cause. But I believe it to be quite important in practice that the physician should be able to diagnose it promptly. Two of my patients had suffered for years from a tormenting eczema of the anus and perineum—not the chronic form of eczema with infiltration, but a frequently returning and peculiarly obstinate acute eruption. In both, the disease had been caused by the wearing of iodoform suppositories for the relief of rectal disorders. This fact being ascertained, their sufferings were easily ended. In two cases of females, similar eruptions broke out over the inner surface of the thighs, whenever iodoform had been applied to the vaginal orifice.

The worst case I have yet met with was that of a respected colleague and fellow-townsmen of my own. For many years this gentleman was afflicted with a chronic urticaria, whose frequent visitations, though sufficiently annoying, could yet be endured with patience. But to this was added, some months ago, an extensive eczematous eruption, the cause of which, and of its continual recurrence, we were wholly unable to discover, until, while treating an accidental injury to his foot, we found that our patient possessed an idiosyncrasy for iodoform, and that his more recent trouble was solely due to the direct action of that drug. Since which, he has avoided all contact with the obnoxious remedy, and his "eczema" has completely disappeared.

In the treatment of this complaint we rely principally upon cold fomentations, with a five-per-cent solution of acetate of alumina, or washings with a two-per-cent carbol-spirit followed by sprinkling-powders. Of course, the patient must have nothing more to do with iodoform.—A. NEISSER, *Deutsche Med. Wochenschrift*, July 24, 1884.

MOLLUSCUM CONTAGIOSUM GIGANTEUM.

ONLY two cases of colossal molluscum contagiosum are known, that of Hebra and that of Ebert Virchow. The author describes a tumor extirpated October 10, 1881, by Prof. Nicolaysen. It came from an unmarried woman, fifty-six years old. It sprang from the right side of the occiput and had the size of two fists. Its surface was purple, uneven, bled easily, but was not, properly speaking, ulcerating. It was hard, with intervening softer parts. It was not movable. Along the posterior border of the mastoid process were found some swollen glands as large as beans. The patient did well and continued so, at latest accounts, six months after the operation.

Microscopical examination revealed that the tumor was composed of small lobules separated by thin septa of connective-tissue fibres. Each lobule was composed of cells of epidermal type. Nearest the periphery these were flat and horny: more internally, they contained protoplasm, and the centre was formed by the fatty or waxy, shining, round or oval bodies characteristic of molluscum. As in some of them a nucleus could still be made out, Laache supposes they are transformed cells.

Similar bodies have been found interspersed in small numbers in epitheliomas, but the large heaps formed exclusively by them, which appeared even macroscopically, by imparting a particular, paraffin-like shine to the cut surface, are characteristic of molluscum.—S. LAACHE, *Nordiskt Medicinskt Arkiv*, 1882, vol. xiv., No. 21.

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TWO CASES OF CHANCER OF THE LIP.

BY

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New York.

ALTHOUGH, comparatively speaking, the initial lesion of syphilis is rarely found occupying the lip, it was recently my fortune to see two cases in one afternoon, at the University Dispensary, in which the chancre was thus situated.

Chancroid does not appear to be often seen in this location, but of the extra-genital true chancres, that of the lip occupies a prominent place, numerically as well as otherwise.

Fournier found twenty-six extra-genital chancres in a series of four hundred and seventy-one infecting sores observed by him. Nearly half of these were located on the lips. Of the extra-genital chancres recently reported in this country, the majority appear to have been situated in the region of the mouth.

Van Harlingen, of Philadelphia, published in the *Medical Times*, of Nov. 1, 1884, ten cases which had occurred in his practice, which is not a venereal one, from 1873 to 1883. Six of these we find were located on the lip, three of them having resulted from bites. In October, 1883, Bulkley published two cases of chancre of the lip, chosen from a large number or similar cases met with in his practice.

Having been Dr. Bulkley's assistant during the past two years at the New York Hospital, I know that extra-genital chancres are not rarely met with at his clinic.

In the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES of November, 1884, we find a résumé of Taylor's interesting article on chancre of the tonsil, three cases of which had fallen under his observation. The infecting chancre may occur on almost any region of the body. I have met with it on the breast, behind the ear, on the hand, the finger, the lip, and the cheek.

That on the cheek was an interesting case treated by me some three years ago at the North-Eastern Dispensary. The patient, an Irish laborer, had cut himself while shaving with a razor borrowed from a friend. The friend had an eruption on the face and body, and as far as I could gather a history, was suffering from syphilis. He promised to come and see me, but I was never able to verify the patient's statements about him.

I am now able to report two cases which I saw on December 3, 1884, in which well-marked chancres occupied the lower lip on the right side.

CASE I.—Frank L., U. S., æt. 22; single, ballet dancer. Has previously had venereal disease. Six weeks ago contracted a gonorrhœa which he has treated with *injection Brou*. There still remains a slight watery discharge. Since then has had no connection. Two weeks ago noticed a small hard lump on the right side of the lower lip which gradually increased in size until now it is as large as a Concord grape, markedly indurated and slightly ulcerated on the upper and mucous surfaces. The submaxillary and sublingual glands are enlarged and tender. The cervical, post-auricular, inguinal, and Sigmund's glands are all enlarged. The fauces are slightly inflamed.

There is no specific eruption on body, but a remarkable one-sided chloasma occupies the right side of the chest, reaching from the median line in front to the spinal column behind, and from the free border of the ribs to the axilla. The pigmentation is in small plaques except in the axillary region, where it resembles lentigo. The patient states that this condition has existed since birth. Although I had no idea of its being pityriasis versicolor, I took some scrapings from the patches and examined them. The result was negative. Ordered potass. chlorat. gr. v. thrice daily. Not wishing to use anti-syphilitic treatment until the eruption had been watched for, I gave a carbolic ointment to apply to the lip.

Dec. 10.—The surface of the chancre is covered with a yellowish-gray false membrane, hardness somewhat diminished, glandular enlargement about the same. No eruption. Treatment continued.

Dec. 11.—Patient called at my office stating that he had been summoned out of town by a theatrical engagement. Examination of body showed a faint, but characteristic macular syphilide. Ordered tablet

triturate of hydrarg. chl. corros. gr. $\frac{1}{2}$ three or four times daily, and to report upon his return to the city.

A specimen of the slight moisture at the meatus was examined for gonococci, but none were found, although pus-corpuscles were present.

CASE II.—Ida M., U. S., æt. 22, married.

Patient states that two months ago she “contracted a discharge” from her husband who appeared unwell and had a sore throat, and that she separated from him on this account.

Since leaving her husband, she says, she has not been exposed.

About one month ago, she burned her lip slightly with creasote while applying it to an aching tooth. Shortly after this she noticed a hard lump just where the burn had existed. This swelling had increased and hardened, until now it is ivory-like, and causes a projection and eversion of the lip. The inside of the lip is ulcerated over a surface the size of a cent. This ulcer has a dirty gray base and is surrounded by a dark-red areola. The tumor has a shiny surface and is of a purple-red color. Swelling of the submaxillary gland makes the neck quite prominent. The cervical and inguinal glands are enlarged, as are also the ante and post-auricular on the side opposite the chancre. The body, forehead, scalp, and extremities are the seat of a sparse papular and papulo-squamous syphilide which had been noticed a few days before. Over the chest are several circular, waxy papules with border more prominent than the centre, as though umbilicated, which in my experience are found only as an occasional early eruption in syphilis. No soreness of throat, no falling of hair, but tenderness on pressure over breast-bone; ordered pil. hydrarg. protiod. gr. $\frac{1}{4}$, thrice daily.

Examination of the genitals showed a labial abscess and a yellowish vaginal discharge.

The abscess was opened and the pus examined. It contained a great abundance of micrococci, and various other bacteria. A specimen of the vaginal discharge showed myriads of diplococci, bacteria termo, rod-shaped and in chains, outside of pus cells were some groups of cocci, but none of the characteristic groupings of gonococci as found in gonorrhœa in the male.

On December 8, upon examining the genitals, a collection of mucus was noticed in the fossa navicularis and a specimen taken for examination. It contained spermatozoa in considerable numbers; two small groups of gonococci only were found in specimen, one in a pus cell and one just outside. The existence of spermatozoa in the specimen renders the girl's history rather untrustworthy. A specimen taken from the ulcerating surface of the chancre on Dec. 10 showed four or five pus-cells, each containing from four to thirty or forty micrococci, mostly in form of

diplococci or dumb-bells, but some resembling very closely the gonococci of Neisser. The chancre is now quite small, the ulceration has healed, the eruption has almost disappeared, but the glandular enlargements remain about the same.

The precise history of infection is wanting in these cases, but the diagnosis could be easily made from the appearance of the lesion. Other lesions for which it may be mistaken are epithelioma, chancroid, traumatism, and in its early stages, simple fissure of the angle of the mouth, herpes labialis, etc. The striking facts that both these patients were of an equal age, lived in the same street (one East and the other West), and had presented themselves on the same day with almost identical lesions, led me to inquire carefully into their knowledge of each other. I was unable to establish any connection whatever between them.

In both cases, which are still under treatment, slight induration persists at the site of the primary lesion. In each there has been a papular eruption and other secondary manifestations. Case I. now has a few large flat papules scattered over the trunk and arms. There still exists in this case a watery urethral discharge. Although no gonococci were previously found, I have since discovered them in epithelial scales scraped from within the meatus.

102 EAST 57TH STREET, Feb. 13, 1885.

A CASE OF ERYTHEMA NODOSUM COMPLICATED WITH SYPHILIS.

BY

E. C. VIDAL, M.D.,

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JUNE 21, 1884, I was called to see a woman, about forty years old, suffering with an eruption and swelling of the ankles and feet. This latter was so great that locomotion was interfered with.

The eruption had made its appearance about thirty hours before I was called, having been preceded, the evening before, by a swelling of the ankles. It appeared in the form of a confluent efflorescence on the ankles, presenting a dark-red hue. The dorsal surface of the feet pitted exceedingly, as did also the ankles, the left more so than the right. There was likewise a great deal of pain. Above this efflorescence, disseminated over the legs as high as the knees, there was observed a number of maculæ, ranging in size from that of a lentil to that of a large pea, of various shades of red and yellow, which retained their color under pressure of the finger. In addition to these were a few round papules, varying

from a pea to a small cherry in size, which were dark blue or purple in color, and excessively painful upon pressure. The right leg was so painful that the patient could not sleep. I found the hands and feet cold and moist, while the remainder of the body was warm.

When first attacked, there was fever, but no headache ; appetite was good, and the bowels were regular.

I prescribed the horizontal position, tonics, applications of cold water to which tinct. opii was added, to the ankles and feet, and prohibited all alcoholic drinks, to which the patient was addicted. Under this treatment, the eruption gradually disappeared.

June 24, there was little alteration in the amount of œdema ; the pain had been so intense that there had been no sleep obtained during the previous night. From this date the swelling diminished, and the eruption continued to fade away. The largest of the papular eruption disappeared by gradual depression in the centre, and were covered by a hemorrhagic crust. The smaller ones slowly sank below the cutaneous surface, leaving behind a yellowish scale which was readily removed intact, exposing a surface simulating, in color, smoked beef. The pain continued *very* severe on the right side of the right foot, which was the seat of a group of four small tumors, about the size of a bean. The crusts covering these, as well as those on the left foot, which was similarly affected, were removed by the water dressings, and exposed an ulcerous sore about a millimetre in depth.

July 12, the œdema had almost entirely disappeared, and on the right ankle there was extensive desquamation. The sores were healing slowly under a treatment of pulv. iodoform, but there was no abatement in the degree of pain. I now discovered, upon the face, a papular eruption which had appeared since my former visit, the week before. These papules, several in number and as large as a pea, bore the same species of scale, readily removed, exposing the same brownish-red base as above described. On the inner surface of the right leg, near the knee, was an egg-shaped tumor about the size of a walnut, of a purple color, and *exceedingly* painful when touched, its immediate neighborhood being inflamed. It first appeared on the 8th, to partially disappear on the 10th, and then again assume its first dimensions when I saw it. Its longitudinal diameter was directed with the axis of the leg. The appetite had become almost null, and it was found necessary to keep the bowels open with saline cathartics. There was no febrile disturbance.

I would state that I had been treating the patient with pot. iod. for some time, but with no apparent effect.

On 19th, the eruption had extended to the scalp and on the arms ; there was also alopecia. The throat and mouth were in no wise affected ;

there was no headache. On examination, I could discover no primary lesion, and no specific history could be obtained.

I now ordered the "mixed treatment," under which the eruption began to fade away; the swelling of the left ankle disappeared entirely, that of the right to a less extent and much more slowly, and the ulcers healed. About this time I presented the woman to Professor Piffard, who confirmed my diagnosis of the later manifestations, by declaring it a case of late syphilis.

ON VARIOUS METHODS OF TREATING LUPUS VULGARIS, INCLUDING THE USE OF BURR AND HOOK.

BY

GEORGE HENRY FOX, M.D..

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THE removal of lupus by the knife may be considered as obsolete. It is only a short time since this was the chief method in vogue, but it has been superseded in recent years by a number of greatly superior methods of treatment. That excision is effective in removing a small patch of lupus no one will deny; but as our aim should always be, firstly, to remove the disease, and secondly, to leave as slight a scar as possible, the loss of healthy tissue, resulting from the use of a knife, is an insuperable objection to any cutting operation.

The use of the galvanic or thermic cautery is equally objectionable. If sufficient heat is employed to completely destroy the morbid growth, and not merely enough to temporarily cicatrize the surface, there must necessarily be a considerable destruction of healthy tissue and the production of a dense and contractile cicatrix. I have seen a most brilliant result follow the application of the actual cautery in a case of lupus of the cheek, and six months later I have seen the lupus nodules springing up all over the smooth, cicatricial surface. I believe the action of the actual cautery in lupus to be delusive, and in spite of the able advocacy of this method of treatment in recent years, am disposed to utterly condemn it.

The various potential caustics which have been employed with greater or less benefit in this disease are only of service, as a rule, after the disease has ulcerated, or the greater portion of the morbid mass has been scraped away. Chloride of zinc, caustic potash, ethylate of sodium, etc., I have applied after the use of the curette, and although they have evidently lessened the tendency of the disease to return, they have not tended to improve the character of the resulting cicatrix, and hence are

not to be recommended. There are, however, two caustics which may be advantageously used, as they are not liable to destroy the healthy skin to any extent. These are nitrate of silver and arsenic. With a sharp cone of nitrate of silver, large, deep-seated, and isolated nodules of lupus can be bored out and destroyed with greater ease and certainty than with a curette. Where isolated nodules are numerous, an arsenical paste (arsenious acid one part, pulv. acacia two parts) may be applied to a square inch or more of surface with the effect of destroying only the diseased tissue.

In certain cases of lupus vulgaris the dermal curette is almost indispensable. Where the disease has existed for a long time, and involved the entire skin of the affected patch, and perhaps become ulcerated, the mass of soft morbid tissue can be more quickly and readily removed with the curette than by any other means. But one curetting, if not followed by a thorough cauterization of the raw surface, is not likely to effect a cure, and very soon a reappearance of the disease becomes manifest at various points in the form of small, brownish-red nodules. Under such circumstances the use of the instruments to be presently described will be found extremely advantageous.

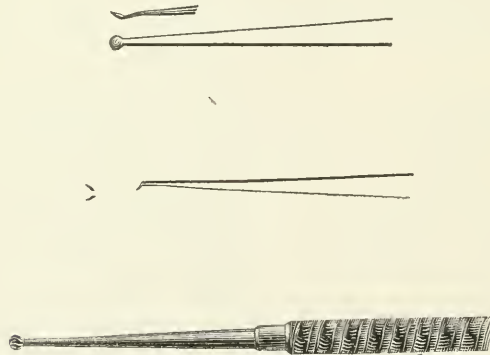
Linear scarification, as recommended by Squire and Vidal, is a slow method of destroying patches of lupus, but in many cases it is undoubtedly the very best plan that can be adopted. The rapid removal of an extensive patch of lupus by the curette leaves a large ulcerated surface, and later a contractile, and often a disfiguring cicatrix. In certain localities this is a matter of little or no consequence, but when the disease is seated upon the nose or near the eyelids, the avoidance of a deforming scar is quite as essential as the destruction of the morbid growth. Linear scarification, if skilfully performed, destroys the lupus cells or sets up an inflammatory process which favors their absorption, and the loss of substance is gradually replaced by a new growth of connective tissue. This plan of treatment is therefore of the highest cosmetic value, and should be invariably employed in every case where loss of tissue is particularly undesirable. An ulcerative lupus of the nose which bids fair to destroy the greater portion of the organ, and which would certainly leave it in an unsightly condition if treated by the curette or caustics, may be successfully treated by scarification, and with a result which is often as astonishing as it is satisfactory.

The foregoing are the established methods of treating a disease which is often obstinate, but never incurable. I desire now to briefly call attention to another plan of treatment, or, at least, to certain instruments which I have found extremely serviceable in the treatment of lupus vulgaris. These instruments are in common use by dentists for the purpose of boring and excavating cavities in the teeth, and nearly every

reader has doubtless had occasion to become painfully familiar with them. Indeed, it was while reclining in a dental chair, and nervously regarding these dread instruments, that the idea first occurred to me that they might be advantageously employed in boring into and excavating the nodules and small deposits of lupus tissue. I have since used them in a number of cases. In a certain condition of the skin, particularly that following other plans of treatment, I regard them as almost indispensable in completing the removal of the disease.

The burr, a steel bulb with coarse or fine threads, may be used of any size from a pin's head to a large pea. Attached to a dental engine or electro-motor, the revolution of the burr may be made so rapid that it will quickly effect the desired destruction of tissue; but for all practical purposes it can be inserted in the handle shown in the illustration, and rolled backward and forward between the thumb and finger while it is gently pressed into the diseased skin. For the removal of large masses of lupus tissue it is not as useful an instrument as the curette, but for isolated nodules it is preferable, while for the removal of very small and deep nodules a small-sized burr is decidedly more useful than a small curette.

The hooked instrument is of service when the greater portion of



the lupus tissue has been destroyed, and there is nothing remaining but small brownish-red points of a pin's head size. Where the lines of scarification have crossed and formed a cicatricial network with rectangular meshes, a few lupus cells are often left in the interstices, and, multiplying, as they usually do in a short time, appear as brownish-red spots. In such a condition of the skin the hook will accomplish what no other instrument is capable of doing. The point of the hook is readily inserted into the dark and yielding speck, and a few revolutions or half turns of the

handle, held perpendicularly or at an angle with the surface of the skin, will quickly destroy the small mass of diseased cells which would otherwise serve as a starting-point for a fresh growth. After the use of the hook I have sometimes thought it advisable to introduce into the cavity the point of a tooth-pick dipped in carbolic acid.

A variety of excavators, differing in size and shape, are used by dentists, and any one may be selected which fancy or experience may suggest. I would urge a trial of the burr and hook, and am certain that in other hands they will prove as useful and, indeed, as indispensable as they have in my own.

TINEA VERSICOLOR OF THE FACE.

BY

C. M. G. BIART, M.D.,

Omaha, Nebraska.

IN the limited amount of literature at my command bearing upon the subject, I fail to find recorded a single case of *tinea versicolor* occurring on the face.

Duhring, in his treatise on "Diseases of the Skin," p. 591, says: "It is never encountered on the scalp or face." Liveing, "Diagnosis of Skin Diseases," p. 190, "Pityriasis versicolor is most common on the trunk, and does not attack the forehead and face, the common localities for *chloasma*." Other authors consulted make similar statements. Morris, "Diseases of the Skin," p. 310, however, states that, "It rarely affects the scalp and face." Hence he admits the possibility of its occurrence in that region, but does not distinctly state that such cases have come under his observation, which would be necessary to positively invalidate the contrary statements of the first-named authors.

Considering the extreme rarity of the occurrence of *tinea versicolor* about the face, the following case may not prove uninteresting:

Ed. C., æt. 31; driver; is a very robust man. He consulted me on July 6, 1884, for a brown discoloration existing on his face. According to his statement, it was spreading rapidly, and he applied for relief merely on account of the resulting disfigurement, as it caused him no other annoyance. He also stated that a similar condition had been present on his body for several years.

On examination, I found a very dark-brown discoloration covering almost uniformly the back and chest, down to a line on a level with the

umbilicus. It extended, also, on the arms; on the right one to just a little beyond the elbow, but on the left arm not quite reaching that articulation. About the shoulders there was more or less irritation, giving the diseased surface in that region a reddish appearance. There was scarcely any desquamation noticeable, the patient perspiring quite freely. A number of variously sized brownish spots encircled the neck, and underneath the lobe of the left ear could be seen a spot the size of a silver half-dollar. Several spots, from the size of a pea to that of a finger nail, were noticed on the left cheek up to the external canthus of the eye. On the forehead, the discoloration, which was very dark, extended from the left temporal region to the middle of the right supercilium, forming a continuous band, irregular in outline. At its broadest part, situated in the left temporal region, it encroached somewhat upon the scalp, following closely the line of the left eyebrow for three-quarters of its length, then narrowing from above and below, terminating in a rather broad point. Here a few detached pea-sized spots were visible.

A microscopical examination of a few scales, scraped from the diseased surface on the trunk, revealed, as I expected, the presence of the fungus *microsporon furfur*. Scales obtained from the patch on the forehead also showed the fungus in abundance. These latter scales were collected and removed with a fresh blade, only after previous ablution of the hands, a new slide receiving them. Still somewhat skeptical, and to obviate all possible source of error, I first proceeded to cure the disease present on the trunk. This result attained, a few scales from the discoloration on the forehead were again obtained, and examined under the microscope, and again the presence of the fungus demonstrated. This placed the diagnosis of "tinea versicolor of the face" beyond a doubt, and the disease in this region was subsequently removed by appropriate treatment.

STRICTURE OF THE URETHRA.¹

BY

FANEUIL D. WEISSE, M.D.,

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IN opening the discussion of the evening, I shall confine myself to the advancing of certain propositions, and to the presentation of certain instruments, to facilitate the diagnosis, and treatment (by dilatation) of stricture of the urethra. I may be over-zealous in my position, but my convictions are strong that the portion of the urethral

¹ Read before the New York Dermatological Society, Jan. 27, 1885.

canal interiorly to the triangular ligament is too often subjected to the unnecessary and harmful introduction of instruments. I refer to the prevailing use of the curved steel sound as taught in surgical text-books and by professors of surgery, and as practised by the profession at large. Knowing that the membership of our Society includes some of the leading genito-urinary specialists, I have taken this opportunity to present the subject.

I would be understood to limit the discussion to stricture consecutive to gonorrhœal urethritis. I would also be understood, when I say "stricture consecutive to a gonorrhœal urethritis," that the gonorrhœa has been the exciting cause which has led to the development of the condition of obstruction, which demands treatment; that I recognize the possible existence of points of narrowing in a urethral canal previous to the occurrence of a gonorrhœa—such narrowings, however, not calling for surgical interference; and that where such narrowings exist, they are the vulnerable points at which a gonorrhœal urethritis produces the tissue changes which constitute the stricture lesion.

1st. That stricture consecutive to a gonorrhœal urethritis is located, as a rule, in the portion of the urethra which is exteriorly to the triangular ligament.

The only positive, practical, and reliable data upon which to establish the *locale* of stricture, from this or any other cause, are to be derived from direct measurements, in living cases, with instruments devised to be introduced into the urethral canal; hence the value of Otis' and Gross' tables of cases.

From Otis' 227 cases (see "Stricture of the Male Urethra" by Fessenden N. Otis, M.D.) of stricture consecutive to gonorrhœal urethritis, 202 or 89 per cent were located exteriorly to the triangular ligament or within six inches of the meatus; and 11 per cent interiorly thereto, or interiorly to six inches from the meatus.

2d. In 89 per cent of cases of stricture from this cause, the passage of an instrument interiorly to the triangular ligament, and into the bladder, is calculated to produce needless pain and avoidable complications.

I need not here allude to the urethral, epididymal, vesical, renal, and constitutional disturbances which may, and not unfrequently do, follow the use of the curved sound, as passed into the bladder for purposes of diagnosis and treatment. Even in skilled hands, the passage of a sound interiorly to the triangular ligament is a surgical manipulation which requires great care and judgment.

I would have it stated, as an *axiom of practice*, by writers on general surgery, by specialists in genito-urinary diseases, and by professors and lecturers, that a stricture or strictures having been located

exteriorly to the triangular ligament, no instrument should be passed, for its treatment, interiorly to the ligament.

3d. *In expressing the location of a stricture of the urethra, the following terms: "penile portion, spongy portion, bulb, bulbo-membranous portion, bulbo-membranous junction, membranous portion," lead to a great deal of misunderstanding. It would be well to use, instead of them, the following: "exteriorly to the triangular ligament, at so many inches from the meatus; and interiorly to the triangular ligament, at so many inches from the meatus."*

The locating a stricture, according as to whether it is exteriorly or interiorly to the triangular ligament, commends itself as an anatomical and appreciable dividing line for classification; it is also calculated to afford precise indications as to etiology, and the selection of methods of treatment.

4th. *It is important to obtain the relations of the dimensions of the penis to the urethra, as follows: 1. The circumference of the body of the penis in the flaccid state; 2. The length of the dorsal surface of the flaccid penis; 3. The calibre of the meatus; 4. The length of the urethra from the meatus to the triangular ligament.*

The first steps in this anatomical direction have been made by Otis, in his recognition of the normal relation of the circumference of the body of the flaccid penis to the normal calibre of the urethra.

I take pleasure in presenting for your inspection the following instruments, which have afforded me great satisfaction:

1. *The penismeter* for obtaining the circumference of the body of the flaccid penis. It consists of a metal tape which is ruled for five inches of its length; it is made to play in a circle—one end perforating the other—so as to adapt itself to any required circumference.

2. *A set of meatometers*, to ascertain the calibre of the meatus. These are short tapering sounds, three quarters of an inch long, spaced off, and the spaces varying from 20 to 32 mms. in circumference (French scale); each instrument represents four or five sizes. They are modifications of Piffard's meatometers, the latter being so long as to be often arrested by a stricture near the meatus.

3. *A set of metal bougies à boules with non-flexible ruled staffs.*

4. *A set of urethral sounds with ruled staffs.*

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

151ST REGULAR MEETING, JAN'Y 27, 1885.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. BRONSON presented

A CASE FOR DIAGNOSIS.

Rosa S., 7 years old. At birth she appeared perfectly healthy and remained so until three years of age, when she had inflammation of the brain with much fever, to subdue which cold applications were made to the head. Shortly after this she had diphtheria, which lasted several days. Some time after it was noticed that she had become deaf. Two years ago, having meantime been perfectly well, except the deafness, an eruption appeared on the face. Shortly after, it was discovered one morning that the skin was covered with red spots, mostly on the legs, buttocks, and arms, less on the body. The eruption was the same as at present excepting that it was redder and the spots larger. One year ago, the patches on the legs and arms began to ulcerate. Her mother says that several spots would run together and form ulcers. About the same time she had ulceration in the mouth, and the jaw could not be opened. Occasionally she has suddenly marked swellings of the hands, feet or knees, which quickly disappear upon pressure; the skin over them is not reddened.

At present, over the cheeks and chin, are a number of irregularly distributed brownish-red papules, varying in size from a pin's head to a split pea, elevated and hard, evidently due to infiltration. There is no affection of the epidermis. The color is of a brighter red in the newer, and darker in the older papules, and leaves dark pigmented stains. On pressure the color does not disappear. On the arms, legs, thighs, and buttocks is a similar eruption. The body, neck, and scalp are free. On the legs, and here and there on the arms, are many depressed roundish or oval cicatrices. There are three or four spots of ulceration, covered by dirty, hard, blackish crusts: underneath the latter the surface is red and bleeds easily. There is no infiltration of the border of the lesion. None of the patches are kidney or serpiginous shaped. The mouth can only be opened one-quarter or one-half an inch because of the adhesion of the chin to the gums, caused by the cicatricial tissue. There are no other cicatrices to be seen in the throat or mouth. No marked adenopathies.

DR. FOX showed two cases of

LUPUS VULGARIS.

Lizzie M., 28 years old; single. Nineteen years ago, the patient had an abscess in the right groin, the present disease extending from the abscess down the legs gradually spreading for twelve years and then ceased in this portion of the body. The eruption appeared eleven years ago as a small pimple over the right eyebrow. Taking this as a point of departure, it has extended over the whole of the right side of the face, involving the nose, upper lip, and the entire tempora-malar region. The chin has small pea-sized and slightly elevated papules, flat and scaly on the surface. The lesion presents the appearance of a red patch, dotted and splashed

with livid-colored interspaces, the whole covered with white, thin scales. The right upper eyelid at the external canthus is drawn outwards and upwards. There is also a small patch of eruption, about four or five inches in diameter, on the right breast, which has been present for the past eight years. All the right thigh, as far as the leg, is involved, also both gluteal regions. Some portions of the skin very greatly resemble ichthyosis.

The second case was that of a woman, 26 years old, who has had the eruption for the last three years. The disease commenced in three separate spots on the right cheek and three other spots at the angle of the mouth on the right side.

At present the lesion occupies both sides of the nose, right cheek, and nostril.

Dr. Fox presented these cases to show the benefit under treatment by means of the dental hook and burr, both of which had been used by him very much during the year past. The dental hook, such as is used by dentists in their operations, is used for the smaller miliary tubercles, the skin being easily punctured and the mass broken up and destroyed. It is simply a modification of the treatment by means of scarification. The dental burr is used for the larger nodules. Afterward the diseased portions are cauterized with nitrate of silver, also carbolic acid.

Dr. Fox then exhibited a case of

EPITHELIOMA.

A. H., 56 years old; farmer. The disease commenced sixteen years ago on the left side of the bridge of the nose, as a small white blister with considerable scabbing. It gradually spread until it occupied its present position. Now all the nose except the tip, all the left side of the face beneath the eye, also the right side of the face, half-way across the cheek, are occupied by a red, granular, and bleeding mass. He gives no history of syphilis. His treatment, since he has been under Dr. Fox's care, has been chiefly local. The case was shown in order to obtain a prognosis.

Dr. BRONSON afterward presented a

CASE FOR DIAGNOSIS.

M. C., 15 years old. The patient is thin and anæmic, with an aged-looking face. He has dark eyes and hair and is somewhat freckled. His teeth are in good condition. He first noticed small pimples on the chest which itched; these gradually increased and lately have been disappearing.

At present, on the lower two-thirds of the trunk and on the arms and thighs to a less extent, is a very abundant red or rose-colored papular eruption, clustered in groups (corymbiform), most of the groups being nummular, many of the papules are most marked at the periphery, while the centres show brownish staining. There is no fluid exudation. Many papules have adherent scales or scratch marks at their summits. In size they vary from a millet-seed to a lentil. At certain points, as the upper part of the arm, the skin is rough, dry, dusky-red, and slightly scaly, with an eczematous appearance. Itching is now moderate, but has been severe. There is some enlargement of the inguinal and cervical glands. No lesions on the penis or mucous membranes. The eruption looks very much like a miliary syphilide, but the larger papules are more rosy in color. There is also some flattening of the surface of the smaller papules.

Dr. ROBINSON showed a case of

PSORIASIS INVOLVING THE PALMS.

Jas. H., 30 years. Has had the present eruption for six or eight years. He now has a general eruption of characteristic psoriasis all over the body and extremities. In some places the lesion presents a pustular appearance. The interesting feature in the case is that the palms of the hands are affected with a dry and scaly eruption, which is undoubtedly a psoriasis. The backs of the hands are also affected. All the patches are of a dusky hue and sharply defined. There is no history of psoriasis in other members of the family. For the past two and a half weeks the patient has been taking acetate of potash and Fowler's solution, with the effect of causing the eruption to slightly fade.

Dr. Fox presented a

CASE FOR DIAGNOSIS.

A man, 25 years old. He has had the eruption for the past ten days, confined to the chest and abdomen, also slightly on the back. It consists of very small fine points, which do not disappear on pressure. There is no itching. The patient's general health is good. The lesion has many of the characters of both purpura and acne.

Dr. Weisse then read the paper of the evening on

STRICTURE OF THE URETHRA.¹

In opening the discussion, Dr. Keyes said that he never cut the meatus unless it was unnecessarily small. Every now and then he is asked to divide the meatus, and he invariably declines unless the patient has definite functional or other symptoms, which might be accounted for by the contracted meatus. The latter condition alone, without symptoms, is not, in his opinion, worthy of surgical interference, simply because it is small. In dividing the meatus for the sake of experimenting, he had always been disappointed in the result. A striking case was mentioned occurring in a reporter who had exciting work, and who was suffering from what is generally known as neuralgia of the neck of the bladder. He had never had syphilis or gonorrhoea, but his urethra was in an extremely sensitive condition. The meatus was small, and Dr. Keyes thought that this would be a promising case for division. The operation was performed, with the result of developing an inflammatory condition of the surface and an increased sensitiveness of the urethra. Anodynes were necessary to relieve the pain and irritation. This was but one of many cases. In his hands the operation was generally unsatisfactory in relieving spasm. This was not so, however, when the orifice was contracted to a small pin-head size, or where there was closure caused by the cicatrix of a chancre, then considerable relief would be afforded by division. But where the orifice would admit of an English twelve sound, he did not think that there would be any benefit. He believed that the instruments shown by Dr. Weisse were eminently suitable for the purposes for which they were designed, the only objection being the number of bulbs required to be introduced, which would cause unnecessary friction. He thought Otis' urethrotome preferable. He did not think that it was necessary to do anything when there was only moderate tightening from causes not traumatic.

Dr. Otis said that he was very much interested in the paper, and thought that the suggestions were exceedingly important, especially those in reference to the harm done by instruments being carelessly passed into the bladder. Scarcely a day elapses in which he does not see bad results follow the unnecessary passage of instruments. Cases of epididymitis were of frequent occurrence from this cause. He cited an instance which he had seen two days ago in whom the spermatozoa were entirely absent, and this resulted from the unskilful passage of sounds. He considered the instruments devised by Dr. Weisse were extremely ingenious. We commonly find strictures of the urethra just within the orifice, and

¹ See page 74 of this issue.

that these are likely to be causes of reflex troubles. He did not think it necessary to enter into a discussion of the value and importance of restoring the calibre of the meatus to that of the urethra. When we find contraction, however slight, there are apt to be reflex troubles, and the urethra should be divided, so that there will be no point of friction when the canal contracts. He finds in these cases that after cutting the urine passes more freely, although the patient was not aware of any contraction before. He had seen cases of Bright's disease where there was considerable pain in the back, which were relieved by dividing the meatus. We may consider the meatus in a pathological state even not when very small. He thought Dr. Keyes was unsuccessful because he did not pay sufficient attention to the matter of rest after the operation. He (Dr. Otis) never divided a meatus unless the patient could be put to bed and kept there a week under the care of a nurse. This was done because of the hemorrhage that was apt to follow, and also because the healing process would set in sooner. The division was made so as to go through the thickened to the soft tissues, and sometimes it was difficult not to make a hypospadias. The instruments were then introduced every day until healing took place, and if there were recontraction he again divided. Dr. Otis referred to the case of a prominent medical man who had an enlarged prostate, pain over the pubes, headaches, and other pains not commonly met with in prostatic disease. The orifice was contracted down to twenty-three or twenty-four, which he divided up to thirty-four. He received a letter from the patient a few days ago, stating that the greatest comfort followed the operation, in fact, a change from a state of misery to one of happiness. He was confident that the change was due to the operation. Thompson and others say that these conditions, viz., indefinite pains in the region of the back and bladder, can be relieved by division of the urethra.

Another case was that of a patient, F. H. B., who had been suffering from a gleet discharge for nearly two years. He was operated upon July 1st, 1873. He had a meatus through which a twenty-four sound could be passed three-quarters of an inch, where there was a stricture; another existing at one and a half inches, which admitted a twenty-two sound. The stricture was cut to thirty, and the sound could be passed through the entire canal. August 28th, a twenty-six sound caught slightly at one inch, and a twenty-nine resisted firmly at one and an eighth of an inch. These points were divided and a thirty again passed. It was subsequently dilated to thirty-one. The discharge continued up to Oct. 10th. Up to Dec. 6th the stricture was dilated to thirty-three, the discharge still continuing. A thirty-three bulb shows a stricture one and one-quarter inches from the orifice, and a half an inch in length, also another at two inches. These were divided with a dilating urethrotome. On January 7th the discharge still continued, and a recontraction was discovered at the site of the former stricture. This was divided to thirty-six. Jan. 27th and 29th, a stricture at one and seven-eighths of an inch was divided up to forty. The patient was under observation for a year, and there was no contraction. Dr. Otis said that the patient came to his office a short time ago and said that he had had no difficulty from his former stricture up to the present time, a period of eleven years. He has been married several years and has children.

Within the last few weeks Dr. Otis had seen two patients whom he had operated upon, and who were free from stricture, although the operation had been performed some years ago. He mentioned these instances to show the advantage of complete division of the stricture.

DR. SHERWELL asked as to the advisability of dividing or dilating a stricture three inches from the orifice.

DR. KEYES said when a patient presented himself with a discharge from the urethra, it was his custom to ascertain from what portion of the canal it came. If the anterior portion of the urethra, there would be a speck of blood or a shred of pus on the bulb; if it is deeper, this could be determined by the surface sensitiveness and threads of mucus, or the quantity of blood, when an instrument passed the tender point. So far as he knew and believed, there was always a tight place between two and four inches from the orifice accompanied by tenderness, because the canal is smaller there. He did not cut unless the narrowing were nodular or immoderately small. He thought that the majority of cases would get well by means of dilatation and injections. A certain percentage of cases do not improve either by the use of injections,

anterior or deep, or by dilatation. If in five or six weeks there is no benefit, then, unless there is some diathetic condition present to contra-indicate the operation, he divides the stricture, because a greater amount of pressure can be exerted in passing large sounds, thus squeezing all the blood out of the velvety tissue and producing a greater activity of the circulation. A satisfactory result is effected directly by the cutting and indirectly by the passage of the instruments. He did not believe that the discharge could be cured by cutting alone if large sounds were not passed. He has seen the discharge continue even when the urethra had attained an abnormal size. In some cases he had seen the patient get well when there was an improvement in health, even when the urethra remained contracted.

DR. OTIS did not at all agree with Dr. Keyes. He did not generally find the contraction two or three inches from the orifice, it generally existed in the peno-scrotal region, to a greater or lesser extent in the majority of adults. He did not really see how Dr. Keyes' view was the correct one, as a very great amount of pressure could not be brought to bear by the passage of large sounds. Another point to be borne in mind is that the patients do not come back again, unless they propose to get married and then they wish to have the discharge stopped. He always has set it down as a rule that where there is a gleet discharge a stricture remains and he would be in favor of dividing at once, without putting the patient through a system of instrumentation.

DR. KEYES said that he wished to correct a wrong impression; he did not aim to cure the supposed stricture when slight tightening existed at a distance of two and a half or three inches, as is the case in a majority of persons, he only attempted to cure the gleet discharge.

DR. OTIS believes that every localized narrowing of the urethra is pathological, except in boys under puberty, who do not have stricture unless they have masturbated. He mentioned the case of a boy the calibre of whose urethra was only two-thirds of its normal size.

DR. SHERWELL referred to a case of acne caused, as he believed, by a stricture. He treated the stricture by dilatation and had passed a sound up to fourteen six times; at first, a thirteen could with difficulty be passed. The acne as well as the stricture was improving under this treatment.

DR. A. S. HUNTER (by invitation) thought the instruments filled a want which had long been felt. He was heartily in favor of not introducing instruments beyond the triangular ligament. He was also pleased because the instruments were not pointed.

DR. WEISSE, in concluding, said that he did not mention anything about cutting the meatus. He was very greatly pleased that Dr. Otis had established the relation of the circumference of the penis to that of the urethra. The one hundred cases which Dr. Otis had examined in reference to this point were of very great benefit in determining the pathological condition of the urethra. Eighty per cent of the strictures were due to gonorrhoea, and if ninety-two per cent of these were anterior to the triangular ligament, and if instruments ought not as a rule be passed beyond the ligament because of the bad results which follow, such as epididymitis, how necessary was it then to have instruments of precision to determine the exact site of the narrowing! Reference was also made to dilatation and pressure which were alluded to by Dr. Keyes; by means of these instruments, the exact point could be ascertained where pressure ought to be applied. Besides, they can be used with safety, as they cannot be passed beyond the triangular ligament. He wished to establish the fact that the majority of cases of stricture existed anterior to the triangular ligament.

Selections.

AN UNDESCRIBED FORM OF STRICTURE AT THE ORIFICE OF THE MALE URETHRA.

IN none of the works on surgery, general or special, which I have consulted, can I find any reference to the form of stricture which I here wish to describe. Apart from its rarity, the condition warrants a special description on account of the troubles it gives rise to and its resistance to treatment. In fact, I have met with no strictures of the urethra which gave both the patient and myself so much trouble as the two cases I have to relate. Indeed, I may say that, as compared with ordinary strictures of the urethra, the treatment of this form has been in my hands complete failure.

The first case was sent me by Mr. Skelton, of Downend. The patient was a strong, healthy laboring man, aged thirty-four, married, with children. He had never had any venereal disease, and no rashes, sores, or any irritative lesion on the glans or prepuce. During all his life, and for the first few years of his married life, he had been able to retract the foreskin completely and without difficulty. Within the past two years the foreskin had become adherent to the glans in a semi-retracted position, as the foreskin usually lay. At the same time the exposed portion of the glans became covered with a hard semi-cartilaginous tissue, which extended into the orifice of the urethra and caused narrowing of the canal. So much had this narrowing proceeded that when I saw him he was able only after violent expulsive efforts to propel the water in a tiny stream. Usually the water came only in drops, and micturition was always attended with great pain.

On examination, the whole of the mucous membrane of the glans penis almost up to the corona was replaced by a dense gristly material, so unyielding as to altogether prevent enlargement during erection. The exposed frenum was greatly enlarged and thickened. Behind the corona a probe, pushed through the adhesion between prepuce and glans, could be moved all round the penis. The meatus was contracted to a pin-point, admitting with difficulty an ordinary surgical probe, and was surrounded with the same dense, unyielding, gristly material. The contraction seemed to extend about a third of an inch down the urethra.

I divided the adhesions between glans and prepuce, finding the corona free from adhesions; slit up the orifice so as to admit a No. 10 English catheter, and tried to dissect the gristly material from the glans. But this last I could not perfectly do, as the tissue extended into the gland substance, and there was no line of demarcation between it and the erectile tissue. After a few weeks it was evident that I had effected no improvement. The surface of the glans got as hard as ever, and the induration along the margin of the prepuce reappeared. But what was most annoying was that, in spite of constant passing of bougies, the meatus speedily contracted again. The passage of a large instrument caused more pain than the patient, though he was a plucky fellow, could bear, and the result was that he was discharged with a No. 4 French rubber bougie, which he passed once or twice daily. He attended some months as an out-patient, and it was only by steady perseverance, in spite of great pain, that he has been able to keep the calibre of the urethra up to the small size it now is

I need not say that he had all sorts of emollient applications—vaseline, glycerin, iodide of potassium ointment, and so forth—all of them useless. All the treatment I could apply did him little good; in fact, as the hardening since division of the adherent prepuce has extended backwards, it may have done harm. He passes a slightly larger stream by the help of the bougie, but the pain from the bougie is almost as great as the pain used to be from micturition through the pin-hole orifice.

My second case, a strong, healthy lad of eighteen, was also an Infirmary patient. He was admitted in May, 1883, complaining of pain and great difficulty in micturition. The urine came in a very small stream or in drops, and he took about ten minutes in emptying the bladder. This had been going on and gradually getting worse for two years. He had had no venereal disease, and up till his troubles began he had had no difficulty in fully retracting the foreskin.

His condition was almost exactly similar to that of the previous case, except that the prepuce was adherent to the glans closer to the meatus, less than half-way between it and the corona; and at one side of the frenum a deficiency in the adhesion easily admitted a probe, which could be freely moved in the cavity so left. There was the same gristly condition of the frenum, and the same extension of the thickening for a little way down the urethra.

The patient would not submit to etherization, and so no operative procedure was possible. The parts were kept soaking in glycerin, and attempts made to dilate the orifice by bougies. This caused so much pain, however, and the results were so slow and so doubtful, that the patient left when the orifice would admit with difficulty a rubber bougie about the size of an English No. 3. I have seen or heard nothing of the lad since.

What is the nature of this condition? That the stricture of the meatus is of the same nature as the thickened and contracted mucous membranes generally is evident enough. But deeper than this into the nature of the malady it is difficult to go. At first phimosis, and the irritation consequent thereon, suggests itself. But neither patient had phimosis, and the adhesions were least where those in phimosis are usually greatest, namely, over and behind the corona glandis. Repeated attacks of herpes progenitalis might be offered as a cause. But both patients denied having suffered from this, or any other eruptive or ulcerative malady whatever. Both maintained that their complaints came on of their own accord, without any apparent cause.

In fact, to presuppose any inflammatory condition would by no means get rid of the difficulty. Nothing less than a severe scald would beget dense cicatricial tissue so evenly distributed over the whole surface; and no traumatic or inflammatory condition which I have ever seen has left so even a surface behind it. In one of the cases the sclerosis and urethral contraction went on steadily under a medical man's eye without the appearance of any inflammation whatever. Mechanical irritation, long continued, might doubtfully start such a condition, but even then the mischief would not go on increasing after the irritation had certainly been stopped.

I believe that, on the whole, we must regard the condition as a true cirrhosis of mucous membrane, as scleroderma is of the skin. It was clearly not a mere epidermic hypertrophy; the sclerosis deeply involved the fibrous tissues of the glans. The dense tissues were anæmic and transparent, as in scleroderma, and exhibited no line of demarcation from the underlying substance.

The local condition—the pale, glistening, hard, contracted dermis, and the

history, owning no irritative or other exciting cause, tally readily enough with the disease scleroderma; but the situation, on mucous membrane, and the existence of adhesions—not very strong, certainly, but still palpable enough—between orifice of prepuce and glans, are against its being true scleroderma, though not insuperably so. If it is not a scleroderma, I can offer no further suggestion as to what it is.

Whatever be its true pathology, there can be no doubt as to the reality and urgency of its symptoms. The pain during micturition is far more severe than we find in cases of ordinary stricture, and the measure of relief which I have been able to give, after much thought and trouble, has been very small. Removal of the contracted orifice would be so much of an experiment that I should not dare to propose it. And yet, if the spontaneous cure which we occasionally see in cases of pure scleroderma does not take place here, I know of no other means of relieving these patients from their sufferings.—J. GREIG SMITH, *Bristol Med.-Chir. Jour.*, Sept., 1884.

ERYTHRASMA.

THE disease on which v. Bärensprung conferred this appellation, in 1862, had already been described by Burghardt, who attributed it to a well-defined parasite—the *microsporion minutissimum*. It has since been very generally confounded, even in Germany, with other dermatoses. The majority of more recent authors omit all mention of it. The existence of erythrasma as an affection *sui generis*, together with that of its specific micro-organism, has lately been demonstrated anew by M. Balzer (*Ann. de Dermat. et de Syphiligr.*, Vol. 10, p. 681 et seq.). It is my object in the present article both to confirm the accuracy of his statements, and to supplement them with the results of my own observations, extending over a series of years.

Erythrasma makes its appearance in the shape of roundish, neatly circumscribed spots, at first punctiform, but gradually increasing to the size of a dollar or of the palm of the hand, without undergoing central degeneration. These spots, at the outset, are strongly distinguished from the neighboring parts by their color, which is found to differ considerably according to the situation, etc., of the patches. When freshly formed the latter exhibit a more or less vivid erythematous redness, either on their borders only, or over their entire surface. As the eruption becomes older, this appearance gives place to a yellow or brownish coloration, that extends only to the superficial horny layers, and hence is easily removed by scratching. Any slight irritation at such localities suffices to restore a good deal of their former tinge, and accordingly we find on the places of predilection for erythrasma that the patches almost always exhibit a yellowish or brownish redness—a combination of epidermal discoloration with the blush of erythema. These differences in color are easily discernible on any single spot. Individual patches are either circular or rosette-shaped and irregular in outline, being formed in the latter case by the confluence of several adjacent maculæ. Unless very red, they are not usually raised above the level of the surrounding skin, from which the examining finger easily distinguishes them by the roughness of their margins. The borders of erythematous spots, on the other hand, are often slightly elevated, owing partly to hyperæmia and enlargement of the papillary layers, partly to a furfuraceous desquamation of the epidermis, which is most pronounced along the edges. In other respects the skin undergoes but trifling alteration, the papillary layers, in particular, even after the complaint has lasted

for years, presenting merely an erythematous redness, followed by a slight increase of pigment in the basal cells of the rete Malpighi. Exudative formations, such as papulæ or vesicles, are never witnessed. The only subjective symptom to be noted is an itching which for a time may accompany a heightened degree of erythema. In a few instances erythrasma seems to have occasioned an unpleasant liability to intertrigo. Generally, however, no annoying sensations whatever are experienced.

The eruption is usually met with on those parts of the surface which are in mutual contact and exposed to the influences of perspiration, friction, etc., and hence normally in a relaxed and moist condition. Consequently, the scrotum, the inside of the superior femoral region, the cleft of the anus, and the axillæ, are the most frequent—generally, indeed, the only—localities of this parasitical disorder. In these regions it spreads slowly until they are completely covered by the eruption, which often invades surrounding portions of the skin by serpiginous extension. In individual cases erythrasma is often seen in a scattered form even on the trunk and extremities.

The course of the disease is markedly distinguished from that of other dermatomycoses by its chronicity. Few patients are able to say when the complaint began to manifest itself—a fact easily explained by the situation of the spots and the absence of subjective symptoms. As a rule, after the patches have reached a certain development, they remain stationary for months or even years. I have only once seen the eruption in its acute stage.

As to the frequency of the disease it is impossible to speak with certainty. According to Balzer and Besnier, it is “not of very rare occurrence.” From my own observations I am inclined to regard it as quite a common ailment, and on a level in this respect with pityriasis versicolor. If we take due account of its peculiarities as to locality, and the lack of troublesome sensations, this estimate will not appear unwarranted.

Erythrasma is well known—although not as an independent affection—both to the dermatologist and the general practitioner. Many of my colleagues have informed me that they have often noticed “those brown spots on the inside of the thighs,” without paying any special attention to them.

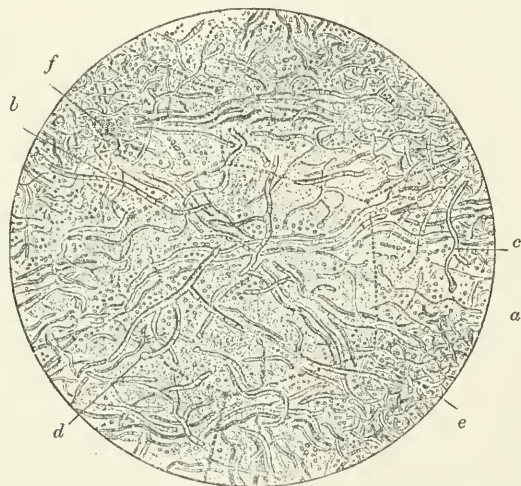
I have never encountered the disease in children. Even Balzer's observations only refer to male adults. Women are seldom affected in this way—so far, only two of my patients were females. The youngest subject was sixteen, the oldest fifty-five.

We have already defined erythrasma as a parasitical disease, caused by the growth of the *microsporon minutissimum*. As in pityriasis versicolor, the brown discoloration of the epidermis is due to this organism, which is found in abundance on every scale. Owing to the superior refrangibility of its elements (in which respect they resemble those of other epidermal vegetations), they are brought clearly into view under the microscope by the addition of an alkali or of acetic acid. The spores are chiefly remarkable for their extraordinary minuteness and delicacy, which might easily cause the conidiæ to be mistaken for cocci, if the characteristic mycelium tubes were not readily made out by a sufficient magnifying power. These mycelium tubes are either simple cylindrical bodies (*a*), of variable dimensions, or their interiors are divided by very evident partitions (*b*). They also ramify dichotomously (*c*), and frequently terminate in small knob-like protuberances (*d*). When occurring in large masses, they are usually grouped very irregularly, so as to form inextricable webs or knots. Bundles of mycelium

tubes are often found radiating in every direction from a single point (*e*). The conidiæ (*f*) are scattered everywhere, and frequently accumulate in great heaps, like those of *microsporon furfur*. The latter parasite bears most resemblance to *microsporon minutissimum*, but its elements are much larger. The accompanying illustration represents a thin scale of epidermis, with mycelium filaments arranged in columns, and aggregations of conidiæ; the whole magnified about 1000 times.

The vegetation is found only in the horny layer of the epidermis. Attempts to cultivate or transfer it, have hitherto been unattended with success.

The diagnosis of erythrasma is comparatively easy, in most cases. The disease is readily differentiated from pigment spots by the desquamation and discoloration which attend it, and by the facility with which the superficially embrowned epidermal layers are removed by scratching. Guided by the same signs, only a very careless observer could mistake smooth pigmented cicatrices for the disorder in question. By far the closest resemblance—as respects the form, color and extent of the eruption, and the condition of the affected surface—is that presented by pityriasis versicolor. Here, not even the almost constant erythematous redness and the remarkable localization of erythrasma, can be regarded as absolutely distinctive, since we often find reddened pityriasis-patches (as in sensitive individuals after washing or rubbing), while, on the other hand, the same disease



is frequently encountered on the favorite localities of erythrasma. In the latter case, to be sure, unmistakable pityriasis-patches will almost always be detected in the body. Notwithstanding this, we sometimes meet with instances in which the microscope alone can decide the question. This instrument is equally convenient and reliable for the purpose, since, in consequence of the abundant growth of their respective parasites in both pityriasis and erythrasma, there is never any difficulty in discovering them, while the elements peculiar to the latter are easily identified by their extreme minuteness. The absence, both of exudative phenomena and of marked alterations in the papillary layer, will prevent us from confounding this disease with either eczema-patches or eczema marginatum. *Herpes tonsurans* and *psoriasis* are still less liable to lead astray. Our safest

course, however, is to avoid all possibility of error by withholding a final decision until the *microsporun minutissimum* has been actually seen.

It is scarcely necessary to remark that erythrasma, like pityriasis versicolor, is among the most innocuous of skin diseases. Its prognosis, in comparison with that of other mycoses, is rendered unfavorable only by the possibility that, in the acute stage, it may overspread large surfaces, or by the occurrence of frequent relapses.

Whether erythrasma admits of spontaneous recovery is a point as yet undetermined. Its similarity, however, to pityriasis versicolor, and the fact that it seldom attacks elderly persons, may be taken as evidence that such a termination is not impossible, at least in the more advanced periods of life.

The treatment of this disease is essentially the same as that of pityriasis versicolor and other parasitical affections of its class. We may either remove the infested epidermal layers by friction with soap, iodine tincture, etc., or we may have recourse to remedies which act by destroying the parasite. The latter require a longer time and are less certain in their operation. Extraction of the hairs from the affected regions seems an unnecessary procedure. From my own experience, I can recommend the application of a one-half-per-cent alcoholic solution of corrosive sublimate, and of the unguent. sulphuratum Wilkinsoni. Chrysarobin, in the form of ointment (10 per cent), or in that of a sprinkling-powder (2 : 100 amyllum) has proved equally efficacious, but the resulting irritation must be held in check, and the contiguous surfaces carefully kept apart by layers of wadding.—GUSTAV RIEHL, *Wien. Med. Wochensch.*, Oct. 11, 1884.

PURPURA VARIOLOSA, VARIOLA VERA, AND VARIOLA SINE EXANTHEMATE IN THE SAME FAMILY.

On the 18th of last May, Agnes W., aged twenty-seven years, was attacked, while menstruating, by severe headache, debility, nausea, and very distressing muscular spasms in the face, body, and upper extremities: these nervous phenomena having always occurred, to a greater or less extent, during the catamenia. As there was now some tenderness on pressure in the right ovarian region, while the bodily temperature only rose to 38.5° C., and was normal in the morning, no special importance was attached to her illness, until, on the 21st, a rigor set in, with increased gastric disturbance and headache, and was followed by a temperature of 40.5° C. At the same time a pronounced eruption resembling scarlatina made its appearance, with a good deal of itching, on the face, forearms, and backs of the hands, together with some œdema in the last-named situation and on the forehead. The eruption soon faded, but re-appeared in a short time, and after shifting about for awhile, was succeeded by a nettle-rash of brief duration. These symptoms were accompanied by a high morning and evening temperature, strong beating of the carotids, and a radial pulse of 120; also by very severe sacral pains, and spasms of the lumbar muscles, which allowed the patient no rest in any position, were influenced by opiates, etc., and were only relieved, after continuing three days, by venesection in the affected region. Rigors returned on the 22d and 23d, the high temperature continued, despite the administration of quinine, and the troublesome retching and vomiting steadily increased, with the addition of severe pains in the precordial region. The intellect, however, was unaffected throughout, and, after cessation of the sacral pains, the patient expressed herself as feeling quite comfortable. May 24th, extravasations were noticed in the left conjunctiva bulbi, with swelling of the eyelids; there was also bloody vomiting, hem-

orrhage from the pharynx and genitals, considerable swelling of the labia, hæmaturia, and severe strangury. The mouth and throat were dry; angina and swelling of the tongue made every act of swallowing extremely painful. Towards evening on the 4th, petechial spots appeared upon the abdomen, temperature was unreduced, and death occurred suddenly in the night of the 25th, just after the patient had remarked to her mother how much better she was feeling. An autopsy was to have been made, but was prevented by unforeseen circumstances.

Although at that time, as I ascertained from my brother-practitioners, not a case of small-pox had been observed in the city district where the patient had resided, and not a single indication of this disease had appeared upon her skin, still I could form no other conception of a complaint attended by such strongly-marked evidences of contagion, than that it must be identical with *purpura variolosa*, of which Curschman nsays, in Ziemssen's Cyclopedia, that "it represents the most unfavorable form that small-pox can assume in the initial stage, tending rapidly, as it does, to a fatal termination, before a sign of the characteristic pustule is discoverable." I mentioned my suspicions to the parents, by whom they were not shared, notwithstanding the confirmatory fact that their house abutted directly on the garden of a soldiers' infirmary, where a few cases of small-pox had lately been under treatment. After consulting with my more experienced colleagues—for up to this time I had scarcely had an opportunity of witnessing for myself the course of a small-pox epidemic—I refrained from vaccinating the family—an omission which I had very soon reason to regret.

June 2, Martha W., a sister of the deceased, began to be affected in a similar manner, except that in this instance the rigors were the first marked symptom to make their onset, after two days of general malaise. They were followed by the same initial eruption, headache, gastric disturbance, sacral pains, and high temperature. The symptoms lasted for five days, and then ceased abruptly, the temperature falling at once to normal, although previously almost uninfluenced by quinine and wet-sheet packing. In four days convalescence was fully established without a single pustule having shown itself.

Immediately on the appearance of this case I vaccinated the whole family. Nevertheless, on the evening of June 4th, a third daughter, Clara, aged twenty-five, and previously in perfect health, was seized by the premonitory rigor, preceded by a fainting-spell. In this instance there was no initial eruption, but but after three days of high fever, small red spots broke out on the face, and next day had spread over the entire surface, accompanied by great restlessness and delirium. The subsequent course of the disease was that of genuine variola. Recovery was complete and without excessive debility, in spite of the enormous supuration.

In all these three cases the contagious disorder manifested itself at the commencement of the menstrual period—a circumstance often noticed in small-pox epidemics. As to the prognostic significance of the introductory symptoms, not much was to be learned from them. The case of variola vera, however, contributed to prove that in this complaint the number of pustules is inversely proportioned to the intensity of the initial eruption.

The hemorrhagic form (*purpura variolosa*) is usually ushered in, as in our first case, by continuous and very severe sacral pains.

I should not forget to mention that Martha W., the patient who suffered least, had been successfully re-vaccinated three years before, while in the case of her

sisters the operation had never been repeated.—CURT NEUMANN, *Deutsche Med. Wochens.*, Oct. 23, 1884.

ROTHELN-MEASLES. ONE HUNDRED AND TEN CONSECUTIVE CASES.

MARCH 30, 1884, a disorder which at first bore a strong resemblance to scarlatina made its appearance in the Protestant Orphan Asylum, Chicago. The earlier cases being of an exceedingly mild character, no persistent attempt was made towards isolation, but the epidemic was allowed to run its natural course. This it did with increasing severity, until about June 2, when 70 children were in bed, many severely and some fatally ill. The disease now assumed a more malignant form, in some cases still resembling scarlatina, while in others it could not be distinguished from ordinary measles.

One hundred and ten of the one hundred and ninety-six inmates of the asylum suffered from an eruption during the progress of this epidemic; the younger the child the greater its liability, but neither age nor previous exposure brought safety.

Average duration in the first or simple cases was four days; in the severer cases the course of the disease was tedious, and where serious complications existed, of course indefinite. From the circumstances of the case, it was generally impossible to fix the duration of the time of incubation accurately. In two cases, however, it was quite definitely fixed at ten days. Of the *complications*—which were rarely absent in the cases occurring after June 1—perhaps the most frequent among the youngest children was *stomatitis*. It was of all varieties—erythematous, aphthous, ulcerative, and gangrenous, one of the latter being a true noma. This last, of course, was fatal; and in some other cases the termination was hardly more desirable, there being so great a destruction of the soft and bony tissues that the children are left permanently disfigured. The symptoms—profuse pyalism, spongy gums, loose teeth, and horrible fetor—had all the appearance of resulting from mercurial salivation, and yet not a particle of mercury had been administered. Convalescence in all these cases has been exasperatingly slow.

Laryngitis was present after June 1 in about sixty per cent of all the cases. Five of these showed well-marked fibrinous exudates: the remainder manifested more or less aphonia or hoarseness. Two of the cases of fibrinous laryngitis died with disheartening rapidity after the first appearance of hoarseness, and the autopsy in these cases showed so extensive an exudate that I am convinced that tracheotomy would have been of no value. On the other hand, one boy, aged five years, after remaining in an aphonic state for nearly three weeks, during which time he suffered repeatedly from paroxysms of dyspnoea which threatened to cut his life short, finally made a perfect recovery.

Capillary bronchitis, or broncho-pneumonia, was the cause of six out of the nine deaths occurring during this epidemic, but no child without previous lung lesion succumbed to this frequent complication. Other complications were: Diphtheria twice, convulsions once, urticaria once, rheumatism once, dysentery once, and decided diarrhoea in four other cases, although looseness of the bowels was by no means infrequent. Ophthalmia and otitis, either or both, were present in about ten per cent of our cases, generally in connection with some other complication. One poor unfortunate suffered from both of the above, as well as purpura, jaundice, diarrhoea, septic pneumonia, and metastatic abscesses, and yet survives to tell the tale.

Desquamation was not observed in the earlier cases, but in the later ones, to the extent of slight branny exfoliations, it was the rule rather than the exception.

Nephritis, with scanty albuminous urine and more or less ascites, showed itself in two cases, which were, however, promptly relieved by the internal use of infusion of digitalis, assisted by vapor baths.

As to *treatment*, the milder cases were simply confined to bed and given an expectorant mixture, as required for cough. If laryngeal symptoms made their appearance, the use of steam inhalations, by means of a Codman's atomizer, was employed about every two hours.

After the loss of the two cases from fibrinous laryngitis, as mentioned above, the bichloride of mercury treatment was adopted in all cases where a similar accident was feared. *Post hoc, or propter hoc*, we lost no more cases in that way, and with our past experience I should certainly try again, under similar circumstances, the hourly use of one-sixteenth of a grain of the bichloride until constitutional disturbance appeared.

The treatment of the severer forms of stomatitis was very unsatisfactory. The removal of the child from the asylum gave better results in obstinate cases than all other measures that could be devised. Where this was impossible, the thorough removal of necrosed tissue by the surgeon's knife, under an anæsthetic, and the subsequent free use of diluted Labarraque's solution and Smith's sulphate of copper mixture, gave us the best results. Generous diet and alcoholics were freely used with advantage in these cases, and Murdock's liquid food served us a good turn in the case of pyæmia previously mentioned.

The *mortality* was a little above eight per cent—a most discouraging result if we accept as true Smith's dictum that rōtheln is never fatal. But of the nine who died three were of syphilitic parents, two were evidently scrofulous, one was already dying of tuberculosis, and the remainder were suffering from chronic bronchitis; so that if we consider it a mixed epidemic of measles and rōtheln, the mortality is certainly rather under than above what might be expected in a public institution.

Finally, this epidemic seems to prove that:

1. Ordinary rōtheln may become so intensified, or complicated with measles, as to be clinically inseparable, one from the other.

2. Previous attacks of measles do not bring exemption from this form of epidemic.

3. The prognosis is graver than with ordinary rōtheln, and less so than in measles under the same circumstances.

4. These facts are theoretically explicable by the hypothesis of a bacterial infection, of increasing virulence, from overcrowding or other favoring causes.—M. P. HATFIELD, *Arch. of Pediatrics*, Oct. 15, 1884.

FATAL CHICKEN-POX.

ON the 8th of December, 1883, a child with a fresh eruption of chicken-pox (varicellæ) was admitted to the City Hospital. The disease ran its usual course, and the child was discharged well a fortnight later.

In a neighboring ward was another child—a girl—three months old, who had only entered the hospital in order to be with its mother, who needed treatment for parametritis, the child itself being in perfect health. On December 19, it began to cough, and showed the stethoscopical signs of bronchitis. It vomited a

a little, the stools became somewhat loose, and it lost seven hundred and fifty grams in weight. On December 27, there appeared an eruption in the region of the left scapula, which was much like a *zona*. It was composed of a row of seven vesicles of the size of pin-heads, filled with a clear, watery fluid, and surrounded by a red ring. They followed about the course of the fifth intercostal space from the vertebral column to the posterior axillary line. Just below the lower angle of the scapula was found a group composed of three similar vesicles. All these vesicles increased in size, until ten days later they were a little larger than peas. The contents were then turbid. Several of them had a central depression; others had already dried up so as to form crusts. At the same time there appeared on both sides of the median line at the nape of the neck, several large irregular groups of about twenty similar vesicles. They underwent gradually the common changes of varicellæ. Finally, one vesicle appeared on the left os bregmatis, and one on the processus mastoideus of the same side. This last one occasioned a small diffuse phlegmon, with necrosis of the subcutaneous tissue. After incision and expulsion of the necrotic parts, the wound presented a healthy appearance. No vesicles appeared on other parts of the skin or the mucous membranes. But in the mean time the child lost flesh and was fretful. It vomited a little, but the stools were normal. On the 3d of January it presented the appearance of a child exhausted with cholera infantum. There were no signs of meningitis, no oedema, no signs of any affection of the chest or the abdomen. The bladder contained a very small amount of clear, light-colored, acid urine, loaded with albumin, but with negative test for blood (no microscopical examination). The next day the child died. The temperature had, during the last eight days, mostly ranged from 38° to 39° C. (100.4 to 102.2).

Autopsy.—The tissue below the crusts was normal. The sore on the processus mastoideus reached the periosteum without implicating it. No affection of the cranial bones. No thrombi in the sinuses of the dura-mater. The meninges vascular, but no signs of meningitis. The cerebrum likewise injected, but otherwise normal. No affection of the spinal marrow. In the lungs only hypostasis of the lower lobes. In the large and small intestines, slight swelling of the follicles; no ulcers and very little injection. The mesenteric glands normal. The kidneys of normal size and consistency. The capsule was easily stripped off. The tissue was somewhat cyanotic. The cortical substance grayish, but the contours completely distinct (no microscopical examination). The spleen was not enlarged, and no other organ showed anything abnormal.

The appearance of the eruption was entirely like that of varicellæ, except the distribution. Thomas (Ziemssen's "Handbuch d. spec. Pathol. u. Therap.," II., 2 p. 10) mentions that the eruption may look like *zona*. There had been no case of varioloid in the city for a long period, and nobody was infected from this child.

In exceptional cases, varicella is not the benign disease which is its common characteristic. Temperatures of 105.8° F. and 106.9° F. have been observed by Henoch and Thomas. The skin affection may become gangrenous. A case which recovered has been published by the Danish physician Petit (*Ugiskrift for Læger*, vol. 6, 1842, p. 49). Similar cases have been observed in England by Abercrombie ("Trans. Pathol. Soc.," London, 1880, vol. 31, p. 333), Barlow and Hutchinson (*Lancet*, 1881, II., 751), and Warrington Howard (*Brit. Med. Journal*, 1883, No. 1, 167.) The author has seen varicellæ followed by considerable diffuse phlegmon in two cases which both recovered. Henoch has published four cases of varicellæ complicated with nephritis, one of which, a syphilitic child, died

(*Berliner Klin. Wochenschr.*, 1884, No. 2). In all these the nephritis appeared between the eighth and the fourteenth day. The author himself has treated a child for nephritis appearing a week or two after the eruption of varicellæ. In this case the urine contained much albumin, blood, and many granular casts. There was no œdema. This child recovered. A similar case has been reported by Dr. G. W. Rachel, of this city, in the *Archives of Pediatrics*, April, 1884.—J. V. WICHMANN, Copenhagen, *Nordiskt Med. Arkiv*, xvi., No. 20.

NERVE STRETCHING FOR ANÆSTHETIC LEPROSY.

THE suggestion first made by Dr. McLeod that nerve stretching might be found useful in the treatment of anæsthetic leprosy, was adopted both in India and Kashmir. In the former country, however, it is now very rarely practised—why, it is difficult to say, since, as far as published cases go, in no other disease has it been attended with such uniform success. I now bring forward 190 cases of the operation, performed in the Kashmir Mission Hospital, upon ninety individuals during a period of three years. Of these ninety lepers, eighty-four improved and recovered sensation, two did not improve, and four died. My own experience was confined to the last thirty-two cases, representing seventy-five nerve stretchings, of which all but one improved.

In most of the lepers who come to us for treatment, anæsthesia is the most prominent, and often the only symptom of the disease, while in the plains the mutilating form is common. Around the anæsthetic parts hyperæsthesia extends, which is commonly a sign of advancing disease. The neurotic affection never, in my experience, extends to the trunk, unless it be merely to a few patches of skin otherwise diseased.

In all but one of the last seventy-five cases there was a definite area affected, corresponding to the distribution of some particular nerve. Of these operations sixty-one were on the sciatic nerve, seven on the ulnar, five on the median, and two on the musculo-spiral. This statement fairly represents the proportion of cases or degree to which different parts were affected. Thus it is most common to find anæsthesia of the feet and anterior aspect of the legs, in many cases the little finger is anæsthetic, and in a few the palm of the hand and the other fingers.

The operation of nerve stretching is of the simplest kind, no dissection being required. Midway between the ischial tuberosity and the trochanter of the femur a vertical incision is made, beginning at the lower edge of the glutæus maximus. The incision should be about 1 to 1½ inches long, and should be made at once through the fascia propria. The forefinger passed under the biceps will, with little practice, at once recognize the sciatic nerve, which should be separated with the finger from its connections, drawn out and stretched. I invariably jerk the leg off the table, using a force of about 25 to 30 lbs., never more than the latter. To the ulnar and median I only apply a force of 4 to 8 lbs. There must always be some risk of injuring the nerves, which in leprosy are weaker than normal. I have twice seen the ulnar broken, once by myself. In neither of these was there any bad result. The operation is almost bloodless, and, with due precautions, would appear to be as nearly absolutely safe as any cutting operation can be.

In none of the last seventy-five operations has there been any inflammation worth recording, nor suppuration. In fifty per cent immediate union of the wound has been obtained. No pain is ever complained of. Within a few days the

patients are always walking about. Normal sensation is recovered by seventy-five per cent of the cases recently operated upon. In most of the remainder sensation was general, though below normal. In a few the feet remained almost entirely anæsthetic. One man alone received no benefit, in consequence of an acute exacerbation of the disease, which almost proved fatal. I have no doubt that though the sphere of this operation is limited, it has yet a great future before it; and that as soon as the certain benefits it bestows become more widely known, it will be as much sought after by the sufferers in India as it is now by the poor lepers of Kashmir.—ARTHUR NEVE, *Edinburgh Med. Journal*, November, 1884.

THE USE OF SALICYLIC ACID IN THE TREATMENT OF LUPUS VULGARIS.

I HAVE for some time employed salicylic acid, in the form of ointment, as a remedy for eczema of the scalp, and impetigo contagiosa occurring in children, with the most satisfactory results, cases that have defied other treatment yielding rapidly to its agency, and I have been induced to make a further trial of it in other skin affections.

By the kindness of Mr. Rigby, surgeon to the Doncaster Infirmary, I was permitted to employ it in a very bad case of lupus exedens, which had been for some time under his care.

The patient, a woman, about twenty-five years of age, had her face terribly disfigured, the ulceration having destroyed one *ala nasi*, the whole of the cheek and eyebrow being also involved. She had been in the hospital before, and had improved under treatment with Donovan's solution and a visit to Harrogate. But on her return, although she was kept under observation and treatment, fresh tubercles developed, and the parts that had cicatrized soon became again involved, and she was re-admitted to the institution. I first tried an ointment of fifteen grains to the ounce of vaseline, which was of no use; I then increased the strength to a drachm, and then to a drachm and a half to the ounce.

The ulcers soon began to heal, no fresh tubercles appeared, the cicatrices became soft and lost their shiny, unhealthy appearance, and the skin of the face is now almost sound. She was taking a mixture containing Donovan's solution and the liquor ferri dialysati. But as this had been administered without apparent benefit before admission, I think it is fair to give the credit to the external remedy. I have not heard of salicylic acid being employed before in the treatment of this particular disorder, and its action seems very satisfactory, especially as it does not appear to cause irritation.—J. G. MARSHALL, *Brit. Med. Journ.*, June 28, 1884.

VACCINIA IN SHE-ASSES.

At a recent meeting of the Académie de Médecine, M. Blachez read a paper relating to an outbreak of *eruptive fever* in the nursery of the Hôpital des Enfants Assistés. In this institution are kept a number of she-asses for the purpose of suckling the syphilitic children. Each of the animals performs this service for one year—feeding three patients daily—and experience had seemingly demonstrated their non-susceptibility to the specific contagion. Nevertheless, several of them have been attacked by a peculiar disorder, under very interesting circumstances. A syphilitic child, with a sore on its lip, was nursed by a she-ass having a mammary ulcer, which had existed previously to the former affection. This

being the case, ought the animal to be regarded as a source of infection? Whether so or not, certain it is that this same she-ass caused an ulcer on the tongue of a second nursing. About the same time, three other asses, all of whom had been suckling syphilitic children, exhibited mammary ulcers precisely similar their companion's. A sucking donkey was next found to have to have ulcerated gums, together with an affection of the submaxillary glands. Finally, one of the female hospital attendants, who had an abrasion on the hand, and whose business it was to milk the asses, was horrified by seeing the raw spot develop into an ulcer, which was speedily followed by a very painful axillary swelling. These were the facts; and the important question now arose, whether it was possible to explain them on any other supposition than that of syphilitic contagion. Professor Bouley, being called upon for his opinion, replied at once that the animals in question had labored under nothing more or less than "horse-pox." A cow having been subsequently inoculated with virus from one of the suspected pustules, this diagnosis was fully confirmed. All the successive phenomena which had occasioned so much perplexity and alarm were simply the effects of *vaccinæ*.—*Le Prog. Médical*.

THE INTERNAL ERUPTION OF VARICELLA.

THAT chicken-pox, like the other febrile cutaneous disorders, may affect the mucous lining of the mouth and throat is a clinically established fact, of which, however, no mention is made by the majority of writers. In most cases this internal eruption is either unnoticed or altogether absent; sometimes, on the other hand, it is quite troublesome and of more importance than the outward symptoms.

According to recent authorities, the interior workings of varicella are not confined to the buccal and pharyngeal membranes; thus, four cases of albuminuria following the disease have been reported in one journal, and a case of nephritis in another. These scattered instances, however, are insufficient to warrant a change in our general estimate of this transient and essentially benign affection.

From a somewhat extensive observation of varicella—especially as met with in a children's dispensary—I am enabled to present the following conclusions:

Varicellous eruptions of the mucous membrane are not of rare occurrence. They are generally found inside the mouth, especially on the dorsum of the tongue and on the palate. Here the vesicles take their rise at an early stage in the disorder, probably sooner than the cutaneous exanthem, but we have never been able to observe them in this situation, owing to their speedy development and rupture, which leaves rounded erosions in their stead. Usually this buccal eruption is of a trivial character, causing but little trouble on mastication. Exceptionally, however, it may set up a severe inflammation, actual stomatitis, which is quickly subdued by chlorate of potassa. In rare cases, the pustular invasion may extend to the mucous membrane of the conjunctiva or of the vulva, but even then it is annoying rather than serious in its manifestations.—J. COMBY, *Le Progrès Médical*, Sept. 27, 1884.

THE OLEATE OF COPPER IN SKIN DISEASES.

THE oleates now used in skin diseases call to mind a home remedy used by my mother years ago. It is to the oleate of copper, more particularly, that I wish to refer. For the cure of eczema and ringworm she prepared a salve after the

following domestic process: About two or three hundred of the old-fashioned copper cents were laid in the bottom of a small copper preserving-kettle, slightly overlapping, so as to leave an open space under each penny. Sweet cream, enough to cover them, was then poured over the pennies, and the whole set in a warm place, not to be disturbed for four weeks. At the end of that time, all things being favorable, through the action of the oxygen of the air and the acids developed, the cream became of a green color throughout. The pennies were then divested of their coating, the cream in the bottom of the kettle carefully collected and thoroughly mixed, and the salve (an ointment of the oleate of copper) was ready for use. It was considered a sure cure for tetter and ringworm, all the country round, and quite a number of remarkable cures might be cited to confirm its merits. In the absence of the old-fashioned penny and the copper kettle, I heartily welcome the oleate of copper, with the positive conviction that mother's remedy has come back to me in more accessible and scientific form.--HOLSBURG, *Therapeutic Gazette*, Oct. 15, 1883.

LABIAL HERPES AND ZONA.

1. THE specificity of labial herpes is as well established as that of zona.
2. In their external manifestations the two diseases differ widely. It is the presence or absence of fever which impresses upon these exanthemata their distinctive aspects. Labial herpes pursues its regular course as one of the *eruptive fevers*; the cutaneous symptoms of zona are much less violent, since it belongs to the class of *simple eruptions*, but it subsequently gives rise to what is denominated by French authors, secondary or suppurative fever.
3. As an exciting cause of labial herpes may be mentioned, first, a sudden check of perspiration. This often happens thirty-six or forty-eight hours before the occurrence of the rigor which foreruns the febrile paroxysm. A second cause is the physiological disturbance induced by parturition. Professor Hardy has remarked the peculiar susceptibility of lying-in women to this complaint, but I believe that the puerperal state not only acts as a predisponent, but is directly responsible for the production of the morbid germ.--LAGOUT, *L'Union Médicale*, July 19, 1884.

BACTERIAL URETHRITIS.

DURING a period of two months, the author, an army surgeon, systematically examined the discharge in every case of infectious urethritis that came under his care, with the result of determining, in three instances, the presence of an organism hitherto undescribed, and concerning which he formulates the following conclusions:

1. Besides those blennorrhagias, by far the most frequent, in which Neisser's well-known gonococcus is always to be found, there are certain other urethra discharges characterized by an abundance of bacterial elements bearing no resemblance to the former.
2. These discharges, like those which contain the gonococcus, may be accompanied by cystitis and epididymitis, and hence require an observance of the same precautions as regards catheterism and exploration of the urethra.
3. It cannot at present be decided whether these newly discovered bacteria originate primarily or secondarily; whether they constitute a type, or merely an accidental product; in other words, whether, in particular cases, the discharge is caused and kept up by their presence alone, or whether they effect their entrance

into the canal, and displace the gonococci, at some time during the progress of the ordinary complaint. Possibly, they act in both these ways.—P. AUBERT, *Lyon Médical*, July 13, 1884.

Items.

AN ABBOT AND HIS ERRING PARISHONER.—*Lyon Médical* quotes the following edifying tale from the *Jour. de Médecine de Bordeaux*. The ecclesiastics, as is well known, have fallen into the bad habit of dabbling in medicine and pharmacy, pretending to know them as well as the Gospels. An abbot named X— was lately the victim of this unfortunate propensity. One of his female parishioners, finding herself in great suffering, consulted a physician in the neighborhood, who regretted to find that she had a well-marked gonorrhœa, and accordingly prescribed copaiba and cubebs in liberal doses. Before taking *these poisons*, the fair one thought it prudent to ask the curate what he thought of them. The latter looked at the prescription and exclaimed, “Balsamics, those are used for the chest. Yours is weak. You can take them.” And, generous to the last, he wrote these words across the prescription, “Furnish at my personal expense.” The story goes on to say that an occasional sly laugh is still called up at the apothecary’s by a perusal of the indorsement on that prescription.

TREATMENT OF SYPHILITIC ONYCHIA.—In the dry form of syphilitic onychia the diseased part should be protected against friction by means of a glove finger or rubber tip, or should be occluded by a dressing of soap plaster. In the inflammatory form, emollients should be used in the earliest stage, then occlusion by bandaging with emplastrum de Vigo. The same means are advised against ulcerous onychia. Prof. Fournier speaks highly of dressings of iodoform; if the ulceration is rebellious, it should be treated with tincture of iodine or nitrate of silver; the acid nitrate of mercury may also be employed, with suitable precautions. Finally, the nail should be removed as soon as possible.—HUMBERT, *L’Union Médicale*, Jan. 3, 1885.

TREATMENT OF LICHEN RUBER BY UNNA’S OINTMENT.—Rockhart has cured in one month a case of *Lichen ruber acuminatus universalis* by means of frictions twice a day over the whole body with the following:

Ung. diachylon.....	500.
Phenic Acid	20.
Sublimate.....	.50 to 1 gr.

—*Monatshefte für Pract. Dermat.*, 1883, No. 3.

TREATMENT OF RINGWORM.—Alder Smith (*Brit. Med. Jour.*, Nov. 1, '84) recommends the use of chrysophanic acid dissolved in chloroform, in the proportion of seven grains to the ounce. He says that it is the most efficient treatment that he has yet tried.



Dr. Taylor's Case of Pigmentary Syphilide.

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ON THE PIGMENTARY SYPHILIDE.

BY

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THE claim originally made by Hardy in 1853, that there is a peculiar pigmentary affection of the skin due to syphilis, is now quite generally accepted in France, England, and America, and within two years its existence has been recognized in Germany.

The chief peculiarities of this affection are the following, which I think are admitted by most observers.

1. That there is a certain chromatogenous affection peculiar to syphilis, which is variously designated, the pigmentary syphilide, the so-called pigmentary syphilide, and syphilitic leucoderma.

2. That the affection appears early or late in the secondary period of syphilis, that it may be the only evidence of the diathesis, or it may co-exist with other manifestations.

3. That its evolution possibly may occur as early as the second or third months of constitutional syphilis, but that it usually appears about the sixth month or towards the close of the first year, and may rather exceptionally be seen to develop during the second and third years. (This is the result of extended observation on my part, and is in accord with the observation of most other observers.)

4. That it occurs most frequently in females, but it is also observed in the male.

5. That it appears most frequently in young persons up to the age of thirty or thirty-five, and that it is rare to see it develop in older persons.

6. That it is seated chiefly upon the lateral portions of the neck, less

frequently on the face (forehead more commonly), and may sometimes be seen on the arms, trunk, and legs.

7. It is composed of irregularly round or oval spots, with either well-marked or ill-defined, even jagged margins of a brown *café au lait* color which does not pale on pressure. The color of the patches may be so faint as to require a strong light, and a certain position for their detection, and even then they might pass for spots of dirty skin. The patches vary in diameter from one-eighth of an inch to one inch, and are never elevated nor scaly. They may be discrete or confluent, in some instances being sparsely scattered, and in others occupying a surface of the extent of one's hand, and presenting very different appearances under the two conditions. In the former, the spots are small and separated by more or less wide intervals of unaltered, or *more or less white skin*.

8. That its duration varies from several months to several years. It rarely disappears under two months. In some cases it is permanent.

9. That it is unattended by any subjective symptoms whatever.

10. That it is uninfluenced in most cases by internal treatment indicated in syphilis, but that it is amenable to appropriate external treatment.

11. That it is to be diagnosticated from chloasma, idiopathic leucoderma, tinea versicolor, from the pigmentations remaining after the disappearance of certain early and late secondary syphilides, from the pigmentations left by eruptions caused by the pediculus capitis and pediculus vestimentorum. Certain leucodermatous spots sometimes left by psoriasis on the parts usually invaded by the pigmentary syphilide might be mistaken for the latter eruption.

These facts thus stated in propositions are generally conceded, the only point now in dispute regarding this interesting affection is, whether it is in reality a leucoderma due to syphilis, or whether it is a true hyper-pigmentation. I have carefully studied many cases of this affection in hospital and in general practice over a period of many years, and I am thoroughly convinced that syphilis causes an abnormal distribution of pigment which we may call, with Neisser, leucoderma syphiliticum, and that it also causes true and distinct hyper-pigmentation to which the name pigmentary syphilide is aptly appropriate. In the following case, carefully observed by me, will be found evidence of the truth of the latter statement.

In the spring of the year 1878, M. S., an unmarried female, a cook, aged 32 years, came under my observation, suffering from syphilis. She had a roseola over the trunk and extremities (my notes say that the neck was normal), active alopecia, mucous patches of pharynx and tongue. The left labium majus was converted into a hard cartilaginous mass, and was superficially ulcerated on its mucous surface. It was on this site that the initial lesion appeared about two months before. She suffered

from rheumatoid pains and nocturnal headache. Though in time antecedent to her attack of syphilis she had been strong and well developed, she was, at the date mentioned, weak and somewhat emaciated. Under appropriate treatment, the lesions disappeared in about two months. During the summer she suffered at times with recurring pains in the bones and with mucous patches. She discontinued treatment in September. During this period she had had a sparse papular eruption on the body. In the winter of this year, 1878, she again came under my observation, suffering severely from nocturnal cephalalgia, which was much aggravated by a too plentiful use of whiskey. At this time she called my attention to numerous spots, varying in color from a light to a quite well-marked brown, seated on the neck and shoulders. These spots, as seen at their most advanced stage, are admirably shown in the chromo-lithographic illustration which heads this article. Though I did not see them until they were well on in the process of evolution, I did have the opportunity of observing some of them appear as very minute spots of the size of the head of a pin, and to gradually grow larger amid the largest ones, as seen in the picture. My interest in the case led me to watch it frequently and critically, and to note all the phases of its progress. Though the patient was actively treated with mercurials with benefit to her cephalalgia, the spots were wholly uninfluenced. The question had been raised early in the year 1878, by my friend, Dr. G. H. Fox, as to whether this affection of the neck was not in reality a leucoderma, and it was ever in my mind. Yet, in spite of the most critical and sedulous study and examination, I was unable to convince myself and several others who saw the case that there was any inter-macular whitening of the skin. It is certain, to my mind, that if the case was considered apart from its syphilitic history, the eruption would have been pronounced to be a chloasma. In this connection I must call attention to an admirable chromo-lithographic illustration of the pigmentary syphilide in the second edition of Fournier's admirable "*Leçons sur la Syphilis.*" In this picture the well-marked, clearly defined brown patches are well shown, seated on a back-ground of normal skin. I think, therefore, that we are not warranted by facts in claiming that the pigmentary syphilide is in reality a leucoderma. I have seen many cases in which the pigmentation, like a delicate web of lace, was seated on a well-marked leucodermatous background. In some instances it was evident that there was decided hyper-pigmentation combined with absence of pigment, while in other cases the pigmentation was so slight, and the leucodermatous condition so well-marked, that I felt convinced that there was no deposit of new pigment, but simply an abnormal distribution of the normal quantity of the pigment of the parts. My conclusions are, therefore, first, that syphilis frequently causes hyper-pigmentation of the skin in spots, without any

visible change in the inter-macular skin ; second, that it causes hyper-pigmentation with co-existing leucoderma ; and third, that it also causes an abnormal distribution of the amount of pigment normally present in a given portion of skin in which there is a preponderance of the leucodermatous appearances coincident with the pigment spots.

DERMATOLOGICAL NOTES.¹

BY

W. A. HARDAWAY, M.D.,
St. Louis.

PRiority as to the Use of Traumaticine in Dermatology. In Dr. Alexander's excellent article on the treatment of ringworm, in the last issue of this JOURNAL, I find that he gives Anspitz the credit of the introduction of traumaticine in cutaneous therapeutics. I was long under the impression that we owed this idea to R. W. Taylor, but I have recently discovered that I was mistaken in this. I thought that I dated my knowledge of combining tar, etc., with liq. guttæ perchæ to Taylor's Lecture on Eczema in the series of American Clinical Lectures for 1876. In looking up the subject, however, I observe that it is collodion and not a solution of gutta percha which he advises as a means of making permanent applications to diseased parts. Several years afterward, Sesemann and G. H. Fox, combining chrysarobin with collodion, advocated this pigment in psoriasis.

In adding ol. rusci or ol. cadini to the collodion, the contractile and not the flexible kind must be employed, since when the latter is used, the mixture becomes too oily and does not adhere well, while the addition of one drachm of an oil of tar to an ounce of the contractile collodion converts it into a perfectly flexible preparation. I know of nothing better than this combination of tar with collodion or liq. guttæ perchæ for obstinate eczema about the mouths of children.

But to return to the traumaticine. Any one who will consult the Transaction of the Am. Dermatological Association will see that on Sept. 1, 1880, Dr. J. E. Graham, of Toronto, speaks of his use of a solution of rubber in chloroform in the treatment of eczema of the hands. Whether

¹ I have jotted down these few notes in the hope that the form in which they are presented may commend itself to others. There are many little practical points that are entirely lost because of a natural hesitation as to their fitness for a formal presentation. I hope that the Editors may see their way toward establishing a department of "Notes," thus giving encouragement to the publication of much that otherwise would never come to light.—W. A. H.

he was in the habit of mixing other substances with the gutta percha solution I do not know ; but certain it is that he anticipated Dr. Auspitz in first calling public attention to the merits of traumaticine, although I think all physicians should be under lasting obligations to the eminent German dermatologist for his method of combining chrysarobin with it in the treatment of psoriasis—a most decided therapeutic advance. It seems clear to me, however, that to R. W. Taylor belongs the credit of first directing attention to what may be called the method of fixed applications in cutaneous practice, a manner of using external remedies of great value, and which has been the subject of much ingenious investigation by Pick and especially by Unna, of Hamburg.

Remedies in the Form of Spray. I presume that many dermatologists have used the atomizer in the treatment of skin diseases, but aside from the recommendation of an ethereal solution of iodoform in spray for puritus vulvæ, I think that the good effects of this practice have not been much recognized. My usual habit is to prescribe a solution of definite strength from which the bottle of an ordinary handball apparatus is filled, and the patient is then directed to throw the fine spray on the parts affected. Any substance that is “sprayable,” either in its liquid form, diluted or pure, or in the state of solution, may be thus employed, *e. g.*, carbolic acid, sulphate of zinc, lotions of grindelia robusta, thymol, liq. picis alkalinus, and fluid cosmoline, medicated or not. In the case of the fluid cosmoline, the tube of the atomizer should be large. The spray finds its greatest range of usefulness in diseases affecting large areas and in that class of disorders accompanied by itching and a more or less unbroken cuticle, viz., pruritus, urticaria, papular eczema, and the like. In generalized pruritus, I have gotten good results from spraying on a lotion of the following sort : Carbolic acid, three to four drachms; glycerin, one ounce; and water, a pint. After the bottle of the atomizer has been filled, I sometimes direct the patient to add from five to ten drops of the oil of peppermint. The atomizer bottle should be thoroughly shaken before the bulb is compressed in order to diffuse the peppermint through the mixture, as otherwise it would merely float on top.

In many instances the spray is far superior to mopping on lotions with a sponge or rag, being neater and less troublesome, getting the remedy more evenly and uniformly applied over the surface, and usually giving more speedy relief.

A Good Needle for Electrolysis of the Hair Papilla. For many years I have been casting about for some needle that would more effectually meet the requirements of the operation for the removal of superfluous hair, than the comparatively stiff kind that I had habitually employed. The desideratum was to get a needle that would readily bend yet not break ; a needle, in other words, that would follow the path of the hair follicle,

much as a soft bougie does the urethral canal, and not make a false passage and altogether miss the papilla at the bottom. I am quite sure that the fine, stiff steel needles, even when the temper is drawn, frequently miss the papilla in this way. Within a year Messrs. A. M. Lester & Co., of this city, have furnished me with a needle composed of iridium and platinum which, when used with proper care, will accommodate itself to the follicular canal, and does not readily break. This needle may also be bent by the finger before introduction to conform itself to the supposed direction of a given follicle.

Removal of Small Pigment Deposits by Electrolysis. The electrolytic current has a wide range of cosmetic application in dermatology. Besides its use in hirsuties, I have elsewhere¹ spoken of its merits in warts, moles, small fibromata, milia, and cutaneous horns. It is equally effectual in scattered, very brown or black freckles. In these cases, one should quite gently and superficially prick the pigment deposit here and there with the point of a stiff needle, taking care not to get down to the corium, thus permanently removing the offending pigment without scar.

A CASE OF "PITYRIASIS MACULATA ET CIRCINATA."

BY

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Lately Clinical Assistant to Dr. T. Colecott Fox, at the Westminster and Victoria Hospital for Children, London.

OF the few cases of this disease which I saw at the clinic of Dr. Fox, the following is a good illustration.

Blanche, aged six, first came under the care of Dr. Fox, at the Westminster Hospital, on January 24, 1884. On questioning the mother, she said the child had very little sickness during her life, and had not suffered from any infectious disease. The present illness began about two weeks previous with an eruption which attracted the attention of the mother, who, observing the uncommon appearance of the skin, brought the child to the hospital. The mother stated that three days previous to the eruption the child was frightened, and that she had a slight cold and sore throat.

The eruption seemed to have come out at night more distinctly than at any other time, although it was well marked on each visit to the hospital early in the afternoon.

The mother stated that the eruption came out in successive crops and

¹ "Electricity in the Treatment of Diseases of the Skin." St. Louis Courier of Med., June, 1883.

increased for some days ; that it appeared first over the back and shoulders, the axillæ and abdomen, that later the face and scalp became affected, and the back of the hands last of all. The spots were red, moderately irritable, rounded in form, and mostly the size of a split pea, with smaller ones intermingled. The disease in no way affected the health or appetite of the child. On exposure to air, the eruption appeared to fade away, but was readily re-developed by a bath or brisk rubbing with the palm of the hand or coarse towel. When the clothing was removed from the child, it was observed that the face, the scalp, the neck, the trunk, the arms and hands, and the legs down to the knees, were covered with thickly disseminated rosecolours, slightly desquamating macules about the size of the little finger-nail. The forehead and palms were free from the eruption.

The mouth was not affected. The eruption over the shoulders, trunk, and back of the neck coalesced in many places ; usually the eruption was discrete. On the limbs especially were there to be seen freshly evolved macules, distinctly raised, and of a faint rosy or crimson color, about the size of a split pea or larger, round and oval and sometimes irregular in outline. A few of the lesions presented a ringed appearance, due perhaps to the fading color, and subsidence of congestion of the central parts. After the macules had faded away, there remained behind a slight desquamation or roughness, more conspicuous in a bright light, and some pigmentation, which resembled very much certain phases of *tinea versicolor*. The scaling was very constant and characteristic; although more delicate than that of *psoriasis*, it instantly attracted notice. The eruption died away in about a month after the child first came to the hospital. In all the cases which I saw, the disease was a week or more advanced, so that I did not see the earliest appearance of the eruption, but from the histories given by the parents of the children affected, it would seem that the macules evolved first on the limbs or trunk, and that the disease bursts out acutely and profusely and continues for several weeks, the symptoms and characteristic features of the disease diminishing each week. Dr. Fox, in alluding to the situation of the eruption at the commencement, pointed out the fact that it did not always begin on the chest, a fact verified by some of his cases, in contradistinction to Gibert, who says that the disease always commences on the chest and fades in the older parts with its extension elsewhere.

Of the cases seen by me, the chief site of the eruption was the upper part of the trunk and arms. Each macule begins as a rosy, very faintly raised, hyperæmic macule, the size of a pin's head or lentil, and gradually increases, the average size being that of the finger nail, scanty fine adherent scales soon form, and the lesions become more or less ringed. Gradually the bright color fades and the macule resembles roughened

discolored spots, which, when abundant, bear a very close resemblance to tinea versicolor. Each macule generally lasts six or seven weeks, and when it disappears, there remains some roughness and pigmentation.

The disease is liable to be confounded with psoriasis, but the scales are not so thick, prominent, and silvery, nor is the distribution similar to that of psoriasis.

The disease is not parasitic, at least no one has yet discovered its fungus (?).

It must be carefully distinguished from the roseolous syphilide, which frequently comes out in the form of rosy circles, one to two centimetres in diameter, with a yellowish tint, on the thighs and trunks of patients.

Such an eruption may last two, three, or four months, and relapse six, ten, or fifteen months after the initial lesion.

THE ETIOLOGY AND PATHOGENESIS OF DRUG ERUPTIONS.

BY

P. A. MORROW, M.D.

ETIOLOGY is commonly considered the weakest, as well as the most difficult chapter of pathology. In the study of the causation of drug eruptions, the problem is much simplified by the elimination of one important element from the list of unknown quantities, viz.: the exciting cause.

The nature of the exciting cause is ordinarily readily apprehended by the physician, or in some cases, suggested by the patient, whose perceptions may have been enlightened by a previous similar experience, or who may be quick to grasp the relation of cause and effect between the ingestion of a drug and the disturbance which oftentimes swiftly follows. In most cases, if there be any doubt as to the causal connection between the drug and the eruption, it is resolved by a comparatively brief expectancy, for, as Bazin has remarked, in no other class of affections is the application of the old adage *sublata causa, tollitur effectus*, so signally appropriate as here. Not only may the *quality* of the exciting cause be appreciated, but, unlike other causes of disease, its exact *quantity* may be definitely determined. It must be admitted, however, that in many drug eruptions the result is entirely independent of conditions of quantity, as it follows indifferently large or small doses.

If the efficient cause of drug eruptions be easily apprehended, the remote or predisposing causes still remain to perplex and baffle the physician; especially is the problem complicated by the existence of that

etiological unknown—idiosyncrasy. Precisely as in the operation of other causes of disease, we find that susceptibility to the irritant action of drugs varies in different individuals and under different conditions. The predisposing causes, such as age, sex, heredity, etc., which exert such a modifying and controlling influence over the production of skin affections in general, play a rôle of minor importance here.

Age and sex seem in no way to dispose the skin to the irritant action of drugs, except from the accident of peculiarities of anatomical structure. As is well known, the texture of the skin of women and children is much less dense and tough than the same organ in man. This greater relative fineness and sensitiveness of the skin renders it more susceptible to take on morbid action, and thus more liable to eruptive disorders from any cause of irritation.

Blond children with fine, delicate, succulent skins are especially liable to eruptive disturbances from the use of drugs, and, besides, the skin of all children is more irritable and prone to disorders of circulation from reflex disturbances. Again, nervous irritability, hysteria, spinal irritation, and other neuroses which, from some unknown peculiarity of organization, are much more common in women than in men, constitutes what may be termed a neuropathic predisposition which markedly modifies the action of drugs.

The comparative influence of heredity as a predisposing cause to drug eruptions is probable from the fact that idiosyncratic intolerance of drugs is rarely an acquired peculiarity. Observations bearing upon this point have not been collected in sufficient number to warrant deductions of a positive character.

Diathetic predispositions exert a marked influence in determining drug eruptions. This has been especially observed in the case of local irritants, the eruption becoming generalized and persisting long after the exciting cause has ceased to act. In these cases it is probable that the drug would be without pathogenetic influence were it not for the predisposition to eruptive disorder constituted by the peculiar diathesis, the existence of which is a necessary condition of its operation. Eczematous subjects are particularly prone to drug eruptions.

The most powerful predisposing cause of the determination of the irritant effects of drugs towards the cutaneous surface is the physiological predisposition known as idiosyncrasy. While the term is intrinsically meaningless, yet it is convenient to express that abnormal susceptibility to external impressions which is manifest in certain individuals, a condition which has been regarded as inexplicable as it is mysterious. The existence of idiosyncrasy as an etiological factor has been accepted as an ultimate fact, unknown and unknowable.

While we may not be able to draw aside the veil which shrouds

this "mystery of individuality," yet it should not be allowed to obstruct what light may be thrown upon the explanation of those phenomena for which idiosyncrasy stands as the *fons et origo* from our knowledge of the physiological properties of the tissues and their mode of reaction to external impressions.

Idiosyncrasy has been termed the bugbear of therapeutics; but this factor, as influencing the action of drugs, is no more mysterious than the predisposition which is manifest in relation to the action of other exciting causes of disease, and which determines the morbid effect to this or that particular organ. To take a familiar example, of a certain number of individuals exposed to the action of cold, as in wetting the feet, the morbid impression may be reflected upon the respiratory mucous membrane, producing in one case sore throat, in another bronchitis, in another pneumonia or an attack of asthma; or it may be reflected upon different tissues altogether, producing in one case neuralgia, in another rheumatism, in another congestion of the kidneys, etc.—the same morbid influence determining disease of a particular organ, varied in form and intensity, or even different diseases. In the explanation of the mode of production of these phenomena, we do not take refuge behind idiosyncrasy as a cloak for our ignorance, but we assume the existence of a textural predisposition in the affected tissues, constituted, it may be, by inherent weakness or antecedent disorder, which renders them *partes minoris resistentiæ*.

So, also, the determination of the irritant action of a drug towards the cutaneous tissue implies either the existence of structural peculiarities of the skin, enfeebling its capacity of resistance, or a heightened susceptibility of the nerves which regulate the circulatory and nutritive processes of this organ. It is by no means clear whether this morbid aptitude of the skin to irritant action is due to anatomical or histological alterations in the cutaneous tissues, too subtle to be seen or demonstrated, or to an abnormality of the nerve-element which may be expressed as "erethism" or "irritability."

Approaching the study of this etiological factor from another direction—Begin defines idiosyncrasy as "the predominance of an organ, a viscus, or a system of organs." Experimental investigation has demonstrated that "the law which governs the susceptibility to the action of drugs is that the more highly specialized any system is, the more readily it is affected by a medicinal agent." We find in persons most susceptible to anomalous eruptions that the nervous element or temperament predominates.

And, moreover, since the same individual may exhibit two or more idiosyncrasies, this peculiarity of development may be manifest in relation to both the skin and nervous system. Conjoined with this highly wrought

nervous organization, the skin itself may be more highly differentiated by fineness and delicacy of structure and endowed with a more exquisite sensibility. We have seen that women and children who, as a rule, possess thin, delicate skin, are peculiarly prone to these eruptive disturbances. Again, as an evidence of the fact that pathological predispositions are analogous to physiological predispositions, we find that neuropathic individuals, the nervous, hysterical, patients debilitated or cachectic, or who suffer from any of the protean forms of neurasthenia, are precisely the persons most liable to manifest idiosyncratic intolerance of drugs. A predisposition to drug eruptions may inhere in the skin from "native debility," or it may be created by any disorder which weakens the tissues, just as a non-specific inflammation of any organ disposes it to more readily take on subsequent inflammation. It has been observed that one attack of a drug eruption seems to confirm and intensify the susceptibility to subsequent attacks.

PATHOGENESIS.—There is a difference of opinion among writers as to whether these eruptions should be classed among the physiological or toxicological effects of the drugs producing them. The term pathogenesis, implying a pathological process, is employed with a clear recognition of the close lines which unite the physiological and the pathological. As pathological states are but modifications of the healthy state, so the toxic effects of a drug differ in degree, but not in essential nature from its physiological effects; there is no definite limit where the one ends and where the other begins. A large proportion of drug eruptions are an expression of the drug's physiological action, while others are merely incidental thereto. These last depend upon conditions of the organism, obscure, no doubt, and imperfectly understood, but which the element of accident does not place beyond the pale of the physiological.

Excluding from consideration the class of agents known as escharotics, we will first briefly refer to the changes in the skin caused by the external application of certain drugs. The links in the relation between cause and effect are here distinctly traceable, and the mechanism of their action is explicable on purely physical and chemical grounds. The intensity and severity of the congestive and inflammatory disturbance produced depend upon the nature of the agent employed, the duration of its contact, and other circumstances, such as the sensibility of the skin and the mode of reaction of the individual. Certain effects, to be considered later, are the result of the absorption of the drug through the skin, and are analogous to those which follow its internal administration. A clinical distinction may be made between effects which invariably follow contact with certain drugs and those which are occasional and irregular in their manifestation.

The first class of effects is determined rather by the nature of the drug

than by any peculiarity of organization or mode of reaction of the skin. They are so constant and characteristic that we may recognize the nature of the agent employed by the form of its lesion. The blebs of cantharides, the pustules of antimony and croton oil are characterized each by a special evolution, and are as typical in their forms as are the pustules of variola. We cannot explain why the irritating influence of different drugs are exerted upon different constituent elements of the skin, any more than we can explain why the pathological changes met with in measles should be grouped around the blood-vessels and glands, while in scarlatina the pathological process affects the tissue proper of the derma, as well as the cells of the epidermis.

In general, it may be said that the effect of a cutaneous irritant is limited to the vascular area supplied by the affected nerves. The irritating effect may sometimes pass beyond this limit and invade adjacent portions of the skin, or it may be diffused over the entire surface. This may be explained by the existence of sympathetic lines which unite different portions of the same apparatus, or upon the assumption that it is due to the absorption of the drug and an expression of its constitutional action.

The second class of effects is far from being constant. Their production seems to depend less upon the intimate nature of the exciting cause than upon a specific predisposition of the cutaneous tissues to disordered action, which may be expressed by the term *morbid aptitude*.

As in the case of anomalous eruptions from the internal use of medicines, the eruptive form is determined rather by the individual than by the drug. Thus we recognize in "tar acne" the specific irritating effect of tar upon the cutaneous tissue; but in one individual the use of tar may produce a simple dermatitis, in another erysipelas, in another a pustular or a furuncular inflammation, while, in the large majority of individuals, it will cause no eruptive disturbance whatever, the difference of the effect depending upon the reaction of the skin in different individuals.

This variation in susceptibility to irritant influences of the skin of different persons may depend upon physiological conditions, such as a greater fineness or delicacy of texture, or upon a peculiar excitability or irritability of the sensory nerves which disposes them to take offence at the slightest provocation. We find that this vulnerability of the skin which renders it abnormally incapable of resisting disturbing influences is manifest in relation to poison ivy, vegetable parasites, the exciting causes of eczema, and, in fact, all external irritants.

The cutaneous changes caused by the external application of drugs admit of a simple explanation. The drug acts just as caloric or mechanical irritants do, upon the nerve element alone, the resulting changes be-

ing phenomena of irritation. The irritation of the peripheral extremities of the sensory nerves causes a paralysis of the vaso-motors of the vascular area affected, which results in dilatation of the blood-vessels, and which may go on to typical inflammation of the skin with exudation. In one case the specific character of the irritant determines the eruptive form; in the other the response to the stimulus is materially modified by the physiological properties of the tissues affected.

We come now to a consideration of that class of eruptions which result from the introduction of drugs into the system by way of absorption. Instead of a direct irritant influence upon the skin, the drug stimulates all the blood-containing organs with which it comes in contact. It affects the centres of sensibility as well as the peripheral nerves, and the pathogenetic mode is much more mysterious and difficult of comprehension.

The eruptive disturbances which follow the internal use of drugs may be divided into two classes :

1st. *Common, specific eruptions* which are more or less characteristic in their anatomical form, mode of development, and locality affected, and which are associated with the other physiological effects of the drug.

2d. *Incidental, anomalous eruptions* without distinctive form or character, which manifest dissimilar eruptive elements, and which may be associated with the physiological effects of the drug, or merely incidental thereto.

In this connection it may be well to recall some of the more characteristic features of drug eruptions. In the first place, it must be borne in mind that the same eruptive form may be produced by different drugs, and that the same drug may produce a variety of eruptive forms. It is not possible, therefore, to establish a distinction between these classes based exclusively upon the anatomical form of the lesions, since one drug may exhibit characteristics of both classes. Thus the type of the quinine exanthem is erythematous, but exceptionally, it may be eczematous or purpuric. Iodide of potassium ordinarily produces a papular or pustular eruption, but instead, or indeed coincident with this specific form, there may be an anomalous eruption of dissimilar forms. In cases reported by Pellizzari, for example, side by side with an acneiform eruption there were bullæ and large subcutaneous nodules.

Again a drug eruption, the type of which is erythematous, may, under special conditions, such as the prolonged continuance of the exciting cause, be developed into a papular, vesicular or pustular eruption.

In other cases, there is no mutation of forms, the indefinitely prolonged use of the drug will be unattended with any essential change in the character of the eruptive element. If it commence as a papular or a pustular eruption, it will continue as such, independent of the dose or duration of the drug. It is to be noted, however, that when the lesions

are in process of involution, if the drug be renewed, it will cause a *poussée subintrante*, and we may have different forms side by side, some in active evolution, others representing the acme or completion of the morbid process. while others are on the point of disappearance.

We perceive, then, that in endeavoring to appreciate the mode of production of these eruptions, it is impossible to adhere closely to the distinction between specific and anomalous eruptions, since there is nothing absolutely constant, nothing definite, nothing fixed in their respective forms, they are as varied in their manifestations as are the physiologicical peculiarities of the individuals producing them. It is to be observed, however, that difference in effect does not necessarily imply difference in mode of impression. We think that most writers err in attempting to differentiate pathogenetic modes upon the basis of difference in anatomical form of the lesions. Anatomical form is as misleading in pathogeny as it has proven defective as a basis of classification. Notwithstanding the diverse character of drug eruptions as indicated above, we have seen that they all possess one distinctive, generic feature, which stamps them with the seal of a common causality of origin—they always promptly disappear on the withdrawal of the exciting cause. The more or less rapid removal of the cause is of course subordinate to conditions of elimination; the celerity of this process varying in the case of different drugs. The rapidity of the disappearance will also vary according to the nature of the lesions; obviously the slight cutaneous disturbance expressed by a simple erythema would not require the same time for its involution as the more profound tissue changes, represented by an inflammatory nodule, or an ecthymatous ulcer. Again, it is to be borne in mind that diathetic predispositions awakened into activity by an irritant drug may impress the character of chronicity upon the resulting skin lesions—the inflammatory fluxion to the surface persisting long after the cause which determined it has ceased to act.

(To be continued.)

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

152D REGULAR MEETING, FEBRUARY 24TH, 1885.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. ROBINSON presented a case of

ACNE.

The patient, a single man, 25 years of age. Has had the present eruption

for about four years. The whole area of the back, extending from the neck down to the sacrum, is covered with acne, there being many indurated lumps, as well as large pustules. Scattered between the acne papules are large cicatrices produced by the breaking down of former papules and pustules. There is a slight amount of eruption on the face and chest.

Dr. Robinson said that he showed the case on account of the extent of the eruption on the back and the great loss of tissue.

Dr. SHERWELL showed a case of

ICHTHYOSIS.

Julia W., 9 years old. German parentage. The patient's mother noticed the eruption when the child was two months old and it has remained ever since. Now the whole body is covered with a characteristic eruption of ichthyosis: the face, hands, feet, and upper and lower extremities are affected, the lesion also extends beyond the labial folds on to the mucous membrane at the entrance of vagina. The axillæ appear to be the only portions of the body free from eruption. There is also a great amount of ectropion.

Dr. MORROW thought that there was a greater generalization of the disease in this case than is usually met with. He had never seen the lesion developed on the palms and soles to such an extent. He also thought that the development of the disease as early as the second month was of very rare occurrence. Numerous inquiries which had been made relative to the time when the ichthyotic condition was first observed would seem to indicate that it is rarely noticeably present at birth or within the first six months. There is a superstition among the common people that the mother's milk has a preservative influence against the development of the disease. He would explain this apparent exemption during the earlier months of infantile life by the fact that in consequence of the skin being more soft and tender, and it being subjected to frequent ablutions, the epidermal scales were not allowed to accumulate.

Dr. TAYLOR asked Dr. Morrow if the frequent ablutions prevented the development of the disease.

Dr. MORROW said that they did prevent the accumulation of the scales which were the evidences of the disease, although the development was not retarded. In proof of this assertion he cited the fact that patients suffering from ichthyosis were much better in summer; because of the increased perspiration and also the more frequent cleansing of the affected surface.

Dr. TAYLOR wished to know, if there were a tendency to an eruption of ichthyosis, if washing would not be apt to hasten the appearance of the lesion.

Dr. MORROW did not consider ichthyosis an eruption, but a congenital malformation of the skin.

Dr. SHERWELL said that he merely presented the case because the lesion covered such an extensive area.

Dr. ROBINSON said that he did not regard ichthyosis as an eruption in any sense of the word, but an abnormal growth of the corneous layer of the skin, so that washing would prove beneficial because it would remove the scales that were constantly being formed. He always had found the sweat glands well developed and he attributed the dryness to the excessive formation of scales which prevented sweating. He thought that there would be as great dryness in a severe case of squamous eczema. He had, however, found the sebaceous glands undeveloped.

Dr. BRONSON showed a case of

PAPULO-ERYTHEMATOUS ERUPTION WITH ECTHYMATOUS ULCERATION DUE TO TROPHONEUROSIS

which was presented for diagnosis at the last meeting. The patient, Rosa S., seven years old, with a peculiar papular eruption, situated on the upper and lower extremities.

Dr. Bronson showed the case that the improvement in the child's condition might be seen. In most instances the papules had disappeared, leaving only efflorescences. In some places, as on the right elbow, there were ecthymatous masses, and on the legs there were a few patches covered with a scab, which, when removed, revealed a granular surface beneath. The treatment had been small doses of Fowler's solution.

NARRATION OF CASES.

DR. JACKSON said that he had lately seen a case of

SUPERFICIAL EPITHELIOMA OF THE UPPER LIP,

occurring in a patient sixty years old. He mentioned the case because of the rarity with which the disease occurs in that situation.

DR. SHERWELL then made a few remarks on the use of

PURE BENZOLE IN THE TREATMENT OF EPITHELIOMA.

He now had a patient under treatment, suffering from cancroïdal ulceration (rodent ulcer) around the eye, to which he was applying pure benzole. The object was to mummify the tissues, as it were. The application did not cause pain, but on the contrary, acted as an anæsthetic destroying the sensibility of the parts and blanching the cells. After a short time a scab is formed which should be removed and more benzole applied. He was inclined to think that it could be used in cancer occurring at the os uteri. He had used the drug at the suggestion of Dr. Mathewson, of Brooklyn.

DR. BRONSON asked if the preparation could not be used in Paget's disease of the nipple.

DR. TAYLOR then gave the history of a case of

FOLLICULAR CHANCRE OF THE PENIS,

two cases of which he had lately seen. He narrated the case because very little had been written upon the subject of follicular chancre.

On January 5, 1885, a young man, twenty-six years of age, came to me, who said that three weeks before he had connection with a mulatto in Texas. When I saw him he presented behind the sulcus on the dorsum of the penis a little red swelling about the size of a milium, in the centre of which was a depression like the orifice of a sebaceous follicle. There was no lesion of continuity present. At that time the swelling did not appear to amount to much, although the patient was anxious, as he had his doubts in regard to the condition of the woman. This small spot increased until the lump was the size of half a pea, and at the same time the inguinal glands enlarged, as did the dorsal and lateral lymphatics. The depression in the centre of the spot also increased in size and ulcerated. About February 5, the morbid mass, together with the lymphatics, greatly resembled a miniature flute, with the flaring end at the surface. The chancre was then about the size of the end of my little finger, and the lymphatics as large as a goose quill. There was so much œdema present that I gave the patient the protoiodide of mercury internally, and externally mercurial inunctions, with the effect of causing the mass to melt away.

About the same time I saw an exactly similar case.

I believe these to be cases of follicular initial lesion, analogous to the follicular chancreoid.

It seems to me that in these cases the syphilitic secretion must have insinuated itself into the follicle, as there was no abrasion, and I watched the case carefully for two weeks. After the syphilitic matter had been introduced into the follicle, it gradually increased, the hardening process extending at the same time, the walls of the depressed portion were forced open, and the condition described was the result.

DR. MORROW asked if the diagnosis was based upon the fact that the lymphangitis disappeared under the use of mercury.

DR. TAYLOR said that he based his diagnosis on the fact that the sore made its appearance twenty-one days after intercourse, and that infiltration and induration took place in the follicle. What else could it be?

DR. FOX said, assuming that the sore was non-specific, would it not disappear under the use of mercury?

DR. TAYLOR replied that the disappearance of the induration under the use of mercury was to him confirmatory of the fact that the lesion was a chancre, and that the swelling produced by a chancroid could not be removed by mercury.

DR. FOX then spoke of his experience in the use of

COCAINE IN EPITHELIOMA AND HERPES.

He had applied Marsden's arsenical paste to portions of the epithelioma in the patient presented at the last meeting, each time putting it on patches of more than an inch square. He had also used a four-per-cent solution of cocaine with good results, dropping it on the surface, drop by drop, for about three-quarters of an hour until the parts were anæsthetized, when the surface could be scraped without causing pain. He also referred to a case of lupus of the lip in a woman, to which he applied six minims of an eight-per-cent solution of cocaine with the effect of producing anæsthesia. In operating about the nose and upper lip, he passed one of the finest hypodermic needles under the lip above the canine eminence as far as the nerve, and injected an eight-per-cent solution of the drug, and after the lapse of about five minutes, there was complete anæsthesia. No abscess was formed afterward.

DR. MORROW said that he applied a four-per-cent solution of cocaine to a rodent ulcer, involving the nose, upper lip, and cheek. The caustic used was a saturated solution of chloride of zinc, which, when applied without previously using cocaine had caused intense pain, but when the latter was used before cauterizing, he found that the sensibility of the mucous membrane of the nose was entirely destroyed, although at the point where the disease encroached upon the upper lip, the cutaneous sensibility was not materially lessened.

DR. SHERWELL had used a four-per-cent Merck's solution in anal fissure, applying as much as sixty minims. He first introduced twenty minims about two inches above the opening, plugged the part, and waited eight minutes, then introduced twenty minims, waited ten minutes, and finally twenty minims, waiting fifteen minutes. He then introduced the speculum and cut the fissure without causing any pain until collodion was applied, when sensibility returned to a certain degree.

In removing laryngeal tumors, he had not found that the drug produced anæsthesia. He had only met with success when he wished to anæsthetize the parts for the purpose of viewing the posterior nares and back of the throat.

DR. TAYLOR showed a

URETHRAL SYRINGE,

devised by Ultzmann, of Vienna, and used for deep urethral injections. It consists of an ordinary syringe of solid silver, with a graduated hypodermic syringe attached to the upper end. By means of the graduated portion the exact amount to be introduced into the canal can be determined with precision. It is of great service in making injections for the purpose of relieving the aching of the peri-næum caused by masturbation or stricture.

Reviews.

A MANUAL OF DERMATOLOGY. By DR. A. R. ROBINSON, M.B., L.R.C.P.S. Edin., Professor of Dermatology at the New York Polyclinic, etc., etc., etc. Pp. 647. New York: Bermingham & Co., 1884.

As would have been predicted by any one familiar with the professional career of Dr. Robinson, he has produced an exceptionally meritorious work in the one before us. Although this work is not *the* book which the author has long cherished an ambition to write, and although it was written under contract and also under great pressure by reason of sickness and professional occupation, the aid of Dr. Gottheil being found necessary to complete it, the result is on the whole so satisfactory that it furnishes abundant reason for believing that the much larger, more pretentious, and more original work of which it is the forerunner, will prove to be one of the best treatises on dermatology in the English language. It is to be hoped, however, that the promised work will not be very much larger, as this modest production is altogether too heavy for comfortable reading.

Too severe criticism of the larger part of the work is deprecated by the frank admission that the description of a number of the diseases is more or less copied from standard works on the subject, and however strongly the reader may feel disposed to express the opinion that a man who has the courage to undertake to write a book should scorn to copy, yet, as the author's object was to present a concise account of our present knowledge of dermatology, it will suffice to say that the copying and compiling have been done with good judgment, and that Drs. Robinson and Gottheil have not only accomplished the object which the former had in view, but that the product of their joint labors is also a decidedly original and instructive work, the latter not only for the student and practitioner, but also for the better informed specialist, whose mind is supposed to be crammed with the learning contained in the numerous monographs and treatises which have recently appeared.

The opening chapter on the anatomy of the integument is concise and yet comprehensive, and is especially interesting on account of the original views it presents on the obscure subject of terminations of the nerves in the skin. The Pacinian corpuscles are described as being composed of a great number of capsules, concentrically arranged around a central elongated clear mass, and the intimate structure of the capsules is minutely described. It is unfortunate that, in the text, both the tactile and the Pacinian bodies are spoken of only as "corpuscles," and that the foot-note on page 20 may, by reason of the omission of a (*) in the text, be read as referring to either of these structures. The plate given to show the formation of the Pacinian corpuscle does not exhibit the intimate structure of the capsules, and some of the explanatory letters attached to Fig. 15 are not alluded to in the context, which is somewhat puzzling to the reader, who is left to wonder why the figure was introduced. The view advanced so positively by Unna that the ultimate nerve-filaments end in pairs in the prickle-cells of the rete in or near the nuclei, is not supported by Dr. Robinson, who says, very justly as it seems, that, if the cells of the rete afterwards become cornuous cells, this mode of termination can hardly be possible.

The chapter on physiology is extremely condensed, only four pages being devoted to this important subject. Although the conclusions advanced seem on the whole to be in keeping with those held by the majority of recent investigators of this subject, yet exceptions might be taken to some, notably to the statement that "probably all the sweat or watery liquid which reaches the free surface comes from the sweat-glands proper." This opinion may be regarded as misleading, in view of the weighty arguments which have recently been advanced to show the functional participation of various structures in the formation of sweat.

The classification adopted is that of Hebra, with some modifications. A word of commendation is bestowed upon the system of Auspitz, but our author has no respect for the nomenclature of the American Dermatological Association, seemingly because "it was decided by balloting."

The sections devoted to etiology and treatment throughout the book are as a rule extremely satisfactory. The balance is judiciously held between the constitutional and the local origin of the diseases and local and general treatment, undue prominence being given to neither. In discussing the treatment of eczema, the chronic and the acute forms are considered under separate headings, a distinction which will at once strike the eye of the general practitioner seeking aid from the book, and impress this very important matter indelibly upon his mind.

Under lichen planus, we are told that "arsenic should not be given in this disease, as it frequently aggravates the eruption," advice judicious enough on the whole, but somewhat too exclusive, as some chronic cases have undoubtedly been benefited by this agent, and it is justifiable to make a trial with it when everything else has failed.

A separate chapter is devoted to dermatitis, under which a concise but careful description is given of the various drug eruptions.

The most striking feature of the book is, however, the prominence given to the pathological histology of the different diseases. About sixty of the large number of woodcuts are evidently original drawings from specimens made by the author, and although some of them will at once be recognized by readers of the numerous excellent monographs which the author has published during the past ten years, the majority are new, at least to the writer. As a rule, they illustrate in an extremely lucid manner the views advanced in the text, and force upon the reader the conviction that what the author says upon the subject is absolutely true. After looking at Fig. 45, *e. g.*, it is difficult to understand how any one can doubt that hyperplasia of the rete Malpighii is the essential alteration in psoriasis. On the subject of the pathology of this disease, the author refrains from controversy, but presents his views as a statement of facts, which seems justifiable in view of the fact that they have been accepted as correct by so many competent observers, notably Jamieson and Thin.

The distinction between lichen planus and lichen ruber is forcibly brought out, and the descriptions of the two diseases are separated by two hundred pages of the book, which renders it more easy for the student to prevent the resemblance of the names from leading him to confound the two affections. Lichen planus is shown to be due to an inflammatory process in the papillæ and upper part of the corium, and lichen ruber a hyperplasia of the epidermis, "a paratypical keratosis." It would, perhaps, not have been superfluous if the author had told his readers what a paratypical keratosis is, or had told them that they will probably never see a case of lichen ruber unless they go to Vienna, as he does when speaking of prurigo.

Sycosis is described as a distinct disease, and a minute account of its symptoms, pathology, and treatment is given. We are told that the eruption in the majority of cases is preceded by a chronic eczema, and that in the latter disease the papules or pustules are not, as a rule, perforated by hairs, whereas in uncomplicated sycosis this is always the case. The distinction between the two affections would therefore seem to be somewhat difficult in practice without the aid of the microscope, and it may seem to some hardly worth making, especially in view of the circumstance that their treatment does not differ materially.

Pompholyx is placed among the non-contagious inflammatory affections, the author believing it to be a neurosis, closely allied to herpes. The descriptions of the disease given by Hutchinson and Fox are reproduced, and then the history of a case which came under the author's care is detailed. A plate showing the formation of the vesicles without implication of the sweat-glands adds much to the clearness of the description of the pathology of the affection.

Under the term *scrofuloderma*, granulation tumors of the lymphatic glands and their sequelæ are described.

The contagiousness of *molluscum* is denied, and yet the deceptive adjective is retained in the name. Dr. Robinson has never found the tumors to be connected with the sebaceous glands, but has always noticed that they developed from the rete cells in the external sheath of the hair.

Under *tinea trichophytina*, a woodcut is given which shows the fungus to be seated not only in the hair and its root-sheaths, but also in the corium, an observation which, like many others in the book, is original with the author.

The style in which the work is written is not pleasing by its ease and fluency, but is, in the main, rather jerky and stiff, as if written in a hurry and without much pleasure on the part of the writer. There are also altogether too many mistakes, showing careless proof-reading, and the author in one place speaks of himself as "I," and in the succeeding sentence as "we." But these are, after all, trivial defects which detract but little from the value of the work, and will doubtless be corrected in the new edition which will ere long be issued, if the book obtains the large number of readers to which its merits entitle it.

Selections.

LUPUS OF THE PUDENDUM.

THIS remarkable disease affects women chiefly during the child-bearing period of life. I have seen it in a child, but at that age it is extremely rare, and I may interpolate the remark that it does not occur in males, or, at least, is very rare in that sex. The disease is generally said to be very uncommon even in women, but that is not my opinion; in this hospital we are seldom without several cases during the session.

It is curious that a case of *lupus minimus*—one small in measurement—has never been observed to grow into a case of *lupus maximus*—one of great measurement, either of hypertrophy or destruction—or *vice versa*. Yet such growth must take place.

A case of *lupus minimus* may very naturally be classed, on superficial examination, with urethral caruncle, or eczema of the vestibule, or *pruritus pudendi*. A case of *lupus maximus* may be taken for one of tertiary syphilis, or of elephantiasis, or of cancer. I have no doubt that the alleged rarity of the disease is to be accounted for by such mistakes.

Lupus of the female genital organs is best known as a disease of the pudendum and neighboring parts; and these are really far most frequently its seat, but it may spread over the adjacent parts of the thighs and the hips. It may attack the vagina and the urethra and rectum; it may attack the cervix and body of the uterus. I do not know of its attacking the tubes.

It is interesting to notice that the face and the pudendum in women are the favorite seats of this kind of disease; and any one familiar with the appearances in the face recognizes some degree of similarity in cases of the disease in the pudendum. There are, so far as my observation goes, no tubercles to be seen in the pudendal disease. Why this should be so I cannot say.

The cases have a general outward similarity which is readily recognizable; and there is a uniformity of structure as revealed by the microscope—no new or specific elements being found, but the presence of young or growing tissue with many leucocytes, these often grouped around the vessels. Dr. Thin has told me that the disease is histologically unlike ordinary *lupus*, the morbid structure being diffused in the affected parts, not occurring in nodules or tubercles. Whilst in ordinary *lupus* the cells undergo a series of retrogressive changes, in the disease of the pudendum the cells are found either as simple white blood-cells or as ordinary connective cells in various stages of development. In ordinary *lupus* the distinctive cells are associated essentially with destruction of fibrous tissue; in the pudendal disease they are associated with formation of fibrous tissue. I have failed to trace, clinically, any connection of the disease with scrofula. No doubt in some cases it is a syphilitic disease, but we have only very rarely met with evidence of the fact. The women affected are often of a fine, healthy, even blooming appearance. The disease has a peculiar history and such extraordinary changes or transformations as to separate it from every other.

This *lupus* is characterized by ulceration, *lupus ulcerosus*; by destructive ulceration, *lupus exedens*: by hypertrophy, *lupus hypertrophicus*. There may be no hypertrophy in one case, and in another there may be no ulceration, or such destruction as is implied by *exedens*. I have never seen great hypertrophy without some ulceration, but often without marked destruction of parts; ulceration and ulcerative destruction without hypertrophy are not rare. Besides, you have discoloration often, and often inflammation of the affected parts, and of the neighboring organs—the urethra, the bladder, the vagina, and the rectum. We had a case in which there was inflammation and stricture of each of the three passages.

The disease gets its name *lupus* from the ulcerative destruction which it frequently causes. The ulcers, whether exedent or not, secrete pus copiously, sometimes laudable pus, sometimes thin and watery. They may affect hypertrophied parts and have no destructive quality. They may cover a great area, the extent not being discovered until the parts are unfolded. They may burrow and be like abscesses, having small openings; or they may burrow far and wide, and form large, empty caverns with large openings, potential caverns, for the sides mutually touch. They may be numerous. They may heal altogether or only in parts. They may bleed copiously. Their occasional

gnawing quality is often wonderfully displayed in destruction, which may remove the whole ano-perineal region, including the viscera there—the urethra, vagina, and rectum. When the uterus is affected, the peritoneum may be perforated. In *lupus minimus* there may be only little red pin-head spots, which change, healing and reappearing as months go on; or there may be a small scarcely ulcerated patch; or a little ulcer on a urethral caruncular hypertrophy, or on a coriander-seed hypertrophy on the hymen, or near it.

The hypertrophies vary as much as the ulcerations. I have never seen them so great in *lupus* of the face, or of any other part of the body. When great, they are generally ulcerated and generally on their inner sides, or where they are in contact with other parts. Sometimes the hypertrophy of a nympha or of a labium majus, or of both, has no morbid appearance or feeling except size. The same is true of the masses sometimes observed around the anus. In the case of *lupus minimus* so often referred to, the left nympha was, at the end of six years, unexpectedly found in this state. It presented, on histological examination, nothing peculiar, and we would not have known it was diseased had we not seen it previously like its neighbor, and now four times as big. Sometimes there seems to be a new development of nympha, that part not terminating at the side of the vaginal orifice but encircling it posteriorly in a copious frilled healthy-like fold. The hypertrophy may extend over the hip with or without deforming it. It may, in the pudendum, result in the production of large irregularly-lobed projecting masses. In one case we had a fantastic appearance, several rounded white masses hanging suspended by long thread-like white stalks. A large hypertrophy is generally ulcerated somewhere, but I have never seen it destroyed by such ulceration or removed. There is no doubt that in many cases the urethral caruncle is merely one of these hypertrophies.

The coloration of ulcerated parts is always red, more or less pale, or more or less deep. Other parts may have a natural brownish or red tint, or may be deep red, especially if inflamed, or they may be pearly or ivory white.

Inflammation, as I have already said, is not uncommon, more common in the neighboring mucous tracts than in the ulcerated and hypertrophied parts. In the mucous tracts the coloration is deep red, and the secretion of pus is copious. The inflammation frequently leads to stricture. Adjacent parts of skin, as between the hips, are sometimes intensely and chronically inflamed, copiously secreting pus, and this without any distinct ulceration, only a scarcely raw redness without defined edges.

The disease is often marvellously without symptoms, only the inconvenience of the hypertrophy or of the discharge, or of both. A woman with extensive ulceration may think that she has only whites, and cohabit, and bear children; or she may not suspect she has any special disease till she is seized with copious hemorrhage. But there are other cases where, without inflammation, and generally in *minimus* cases, the sensitiveness is extreme, and this great difference in cases has made me doubt the identity of the disease in them. When there is inflammation the inguinal glands may be affected, and they may, though rarely, be affected without inflammation. Of course, when parts are inflamed, we have the usual symptoms of that condition.

From cancer the disease is easily distinguished histologically; but without resort to that evidence, you will know the malignant affection by its appearance, its history, and by the early enlargement of the inguinal glands if it affects the vulva. If the disease is altogether internal, you may have great difficulty in diagnosis.

Elephantiasis is a disease affecting the clitoris or labia only, a great hypertrophy of slow growth, sometimes curiously and regularly nodulated, as in this specimen without the exedent ulceration of lupus. It is also distinguished by histological characters. I know little of it, for it is rarely seen in these countries.

There is a sort of elephantiasis seen in tertiary syphilis, of which I know very little. In cases I have seen the hypertrophy has been considerable, not at all like that of this lupus, nor like the enormous growths of elephantiasis. It is of a uniform dull leaden red color, generally smooth on the surface, sometimes superficially ulcerated in mutually touching surfaces, sometimes fenestrated, and the inguinal glands are affected.

As the lupus varies in its characters with the lapse of time, so it is natural to expect that it should be regarded as amenable to treatment; and, no doubt, great gain may come from treatment, especially surgical interference. This consists in removing hypertrophic masses, and in cauterizing ulcerations; and both these operations are best done by actual cautery; and when the galvano-caustic is available, I prefer it. I do not say you cure the disease by this means, but you have seen cases of great extent and severity very greatly ameliorated by it, the women going away believing themselves cured.

The mucous membrane inflammations are treated just as such inflammations are treated in other circumstances, but we have learned to attach special value to mercurials, using chiefly the *lotio nigra* as a wash, or applied in strips of lint. Under favorable circumstances and treatment, it is interesting to notice the softening or even disappearance of strictures caused by these inflammations.

Constitutional treatment is not to be neglected. Regulation and maintenance of general health, the use of cod-liver oil, of arsenic, and of iron.

Lupus is not a fatal disease, and few autopsies are recorded. They have as yet added nothing to our knowledge of the specialties of the affections.—J. MATTHEWS DUNCAN, *Med. Times and Gaz.*, Nov. 15, 1884.

MULTIPLE CACHECTIC GANGRENE OF THE SKIN.

THIS affection received its name from the late Prof. Simon, of Breslau, by whom, in 1878, it was also first described as a distinct dermatosis. It is comparatively of rare occurrence. During a constant connection, since the foregoing date, with dispensaries for diseases of the skin, I have treated only two cases of the kind—one in 1880, the other within the past eight days—and in the interval the complaint has not, to my knowledge, been observed elsewhere. Both of these patients were children; in fact, adults seem, so far, never to have been attacked in this way. In both instances, also, the disease pursued a very similar course. The subjects, having previously been reduced, from one cause or another, to a condition of profound cachexia, became covered with an eruption composed partly of small dark-red spots, partly of vesicles with sero-purulent contents, and partly of the characteristic deeply-penetrating ulcers, covered with a dry and blackened crust. The eyes were also affected, keratitis being present in one case and conjunctivitis in the other.

When confronted for the first time with this assemblage of symptoms, we regarded it as originating solely in the pre-existing cachexia, which we supposed had caused a thrombosis in the superficial vessels of the skin, resulting in the gangrenous ulceration. In accordance with this idea, we relied in our treatment mainly upon tonic medication combined with bran-baths and mild antiparasitic ointments. Our success was not altogether satisfactory. The cutaneous malady,

indeed, was removed in the course of six or eight weeks, but, owing to the effects of fever (from absorption), the constitutional condition remained unimproved.

Having proceeded in this instance upon a mere hypothesis, we determined, when the next case of the same kind arose, four years afterwards, to provide a surer foundation for our efforts, by making a careful microscopical examination of the ulcer and its products. This was accomplished with comparative facility, disclosing, amid the usual multiplicity of pus-cells and corpuscles, a peculiar vegetation, bearing a strong resemblance in size and character to the trichophyton tonsurans of Malmsten. The great abundance of mycelium-tubes was especially noticeable. Various-sized bacteria were also discovered in immense numbers. The conjunctivitis was likewise found to be of a mycotic nature.

I believe at present that the bacteria have nothing to do with the essential nature of the disease, but are merely accidental accompaniments of the offensive discharges from the ulcers—or perhaps their cause. On the other hand, I regard the fungoid product—trichophyton tonsurans—as its actual excitator, and consequently I look upon multiple cachectic gangrene of the skin, no longer as a simple gangrene arising from engorgement, but at a *dermatomycosis*—by which I mean, not something altogether new, in the sense of being occasioned by a newly-discovered element, but an affection due to the *accidental co-operation of various morbid influences*.

The trichophyton itself, when sown upon a moderately healthy soil, is unable to overcome the resisting capabilities of the cells with which it is brought in contact, and hence will give rise to nothing more formidable than an invasion of herpes tonsurans; but implanted in a cachectic constitution, it speedily conquers in the struggle for existence, proceeds in its destructive career until certain portions of the integument are cut off from their sources of nutrition, and in this way a condition of actual gangrene is established, with all its possible and probable injurious consequences. Many other pathological processes of this sort involve a similar termination. Thus a certain sore which is ordinarily of a benign character may, in one case out of a thousand, be converted suddenly into a soft gangrenous ulcer, and in a few hours commit almost incredible ravages, utterly destroying, for instance, a prepuce or an entire glans penis in a single day, and ultimately spreading much further. In this case, also, the victims are generally cachectic—and the same may be said of diphtheritis and gangrenous variola.

I would suggest that the name originally bestowed upon the disease we are considering be retained, but with the addition of a single term, which would make it read *multiple mycotic-cachectic gangrene of the skin*. Nosologically, I would place the affection under the head of herpes tonsurans.

If these points be now regarded as settled, they are of great significance in their bearing upon the question of treatment. After discovery of a parasite in the ulcers, I ordered for my latest patient a strong thymo-salicylic ointment and baths of soap and water—combined, of course, with appropriate invigorating remedies. These measures, continued for three or four days, produced a marked improvement in the condition of the ulcers, and the child was discharged cured in eight days—while in the previous case as many weeks had been required to bring about a much less favorable issue. The element of time is here of special importance, since, in all cases of gangrene, there is danger at any moment of a thrombosis of internal organs or of general blood-poisoning.

The eye-symptoms are never to be neglected. The early and judicious employment of antiseptics may be relied upon for the attainment of our object in this direction also.—DR. EICHHOFF, *Deutsche Med. Wochenschr.*, Nov. 20, 1884.

PAINFUL SUBCUTANEOUS TUBERCLES.

THE morbid formations thus specially denominated are of such rare occurrence that the author has met with them in only one per cent of the tumors examined daily at his histological laboratory. They are situated within the subcutaneous connective tissue, and are generally movable, though in some cases quite firmly adherent to the skin. Their size varies from that of a small pea to that of the end of the thumb. And they are round or oval in shape, occasionally somewhat flattened. Their surface is usually quite smooth. The neoplasm itself is loosely enveloped in a layer of connective tissue, which forms its bond of union with the neighboring parts. When cut open, it is found to be mainly composed of fibrils which interlace with each other in every possible direction. The color of the tumor is white or yellowish. It is of very firm consistence, resembling in this respect an adult fibroma or a uterine myoma. Its centre is sometimes occupied by a nucleus of bony hardness. As to its intimate structure, all that has been positively distinguished are smooth muscular fibres (*in immense preponderance*), a small amount of elastic fibrous tissue, and some sclerosed blood-vessels, the whole encased by a thin layer of connective tissue. The hardened nucleus is purely calcareous, and without a trace of ossification.

Painful subcutaneous tubercles may occur probably on any part of the surface, but are most commonly encountered upon the upper and lower extremities, especially the latter. The disease commences—sometimes as the result of injury—in the form of a minute swelling, whose growth is so extremely slow that it may occupy ten or fifteen years in reaching the size of a pea or a bean. The tubercle is at first quite painless, except, perhaps, when subjected to pressure. Suddenly—in some cases after the lapse of several years—it becomes the seat of pain, which in the beginning is produced only by blows or other rough usage. Sometimes these sensations retain their intermittent character, sometimes they come to be felt almost continuously and without appreciable cause, or else are excited by the slightest contact, as of the clothing, etc. They are unmistakably neuralgic, extend to a considerable distance, and sometimes acquire an intensity which renders life a burden to the patient. Professional examination of the swelling is almost always followed by an exacerbation of this symptom. The tubercles are perfectly benign, and their extirpation is demanded solely on account of the pain. Their diagnosis is unattended with difficulty, and their removal—by a correspondingly simple operation—at once puts an end to the whole trouble. It has never, or scarcely ever, been possible during the operation to discover any actual connection between the tubercle and the course of any nerve-filaments, whether large or small. Consequently, the relation which a painful subcutaneous tubercle bears to the nervous system has not been established by observation: it can only be surmised.

It is true that M. Chandelux, who has published an interesting series of articles on this subject (*Arch. de Physiol.*, 1882, p. 639 et seq.), includes under the head of painful subcutaneous tubercles *all tumors whatsoever* containing nerves sensitive to pressure. But if this conception be correct—if painful subcutaneous tubercles may comprehend different sorts of tumors—how is it that all these tubercles exhibit precisely the same symptoms? My own researches have led me to the opposite opinion, viz., that true painful subcutaneous tubercles not only present this uniform likeness from a clinical point of view, but that they all belong to a single class of tumors, *i. e.*, to the myomata, not, of course, but that *any* tumor may become painful if it incloses nerves. Daily observation shows

us this in the case of cancers, for example. But there is surely a very great difference between ordinary tumors accompanied by pain and "painful subcutaneous tubercles," the suffering arising from which is quite as pronounced and characteristic as that produced by fissure of the anus or by zona. This difference is readily explained by accepting my judgment as to the structure of the subcutaneous tubercle—a judgment in which I have been anticipated, moreover, by no less an authority than Billroth.

But, admitting the muscular constitution of the subcutaneous tubercles, how are the pains to be accounted for? As not a trace of nerve-substance has been detected in any of our specimens, we have to choose between the following suppositions:

1st. *That the tubercles contain nerves*, concealed either in the depths of the pathological tissue, or in the walls of the blood-vessels. If this be so, it is clear that spasm of the muscular fasciculi will cause pain like that experienced in cramps and colics or from compression of an arteriole. As the tumor develops and exerts more contractile force, these pains increase; they are more or less intermittent, like all muscular pains, and, like all such pains, they are excited by various external agencies.

2d. *That the tubercles contain no nerves*. In this case, when the tumor contracts and becomes round and hard, it compresses the cutaneous nerves in its vicinity like a foreign body. We know how keenly sensitive is the integument to any normal contraction of the *arrectores pilorum*. If, therefore, as is probable, the subcutaneous myoma is developed at the expense of these little organs, we can understand what severe pain they must occasion under the influence of the morbid process; and the fact that this pain is excited by muscular contraction will account for its intermittent and paroxysmal character.—A. MALHERBE, *Gaz. Méd. de Nantes*, Oct. 9, 1884.

TWO CASES OF LICHEN PLANUS

IN WHICH THE ERUPTION WAS DISTRIBUTED ALONG THE COURSE OF CUTANEOUS NERVES, WITH REMARKS ON THE INFLUENCE OF THE NERVOUS SYSTEM IN THE DISPOSITION OF CUTANEOUS ERUPTIONS.

THIS formed the subject of a paper by Dr. Stephen Mackenzie before the Harveian Society of London. The author narrated the case of a woman in whom lichen planus was arranged round one-half of the back and abdomen in belt form, like herpes zoster, for which the eruption had been mistaken. Later the eruption became generalized. There was intense itching of the skin, and white patches on the buccal mucous membrane. In the second case, also that of a woman, the eruption was confined to a track down the inside of one arm corresponding with the internal cutaneous and ulnar nerves, with intense itching in the area of the eruption. Dr. Mackenzie proceeded to point out that these cases were deviations from the ordinary type of lichen planus, which was characterized usually by marked symmetry. He next drew attention to other cutaneous diseases which were distributed along the course of nerves, as herpes zoster, morphea, neuropathic papillomata, purpura, etc. He next considered the anatomical evidence explaining such neurotic eruptions, and by the kindness of Mr. McCarthy, was able to show to the members a microscopical specimen of the spinal ganglia of a case of retroceding zona. He then dealt with the significance of such eruptions, indicating his belief that the local lesions of the nervous centres merely determined the localized eruption, and that there was some other factor

which decided its nature. He instanced some observations of Dr. Moxon, in which the local development of tubercle, cancer and pleurisy were determined by local affections of nervous centres. He then passed in review the circumstances which occasioned symmetry of eruptions, showing that local tissue peculiarities could not be left out of consideration, and that asymmetry rather than symmetry was characteristic of eruptions directly due to local diseases of the nervous system. He thought that symmetrical eruptions like lichen planus and psoriasis were due to some general nerve influence, or diathesis, the symmetry in such diseases being in part due to local tissue influences; and that cases such as he had narrated did not support the view that the ordinary symmetrical distribution was the direct outcome of nervous influence.

DR. MALCOLM MORRIS said that cases of localized lichen planus, like zoster, were very rare. He referred to a communication in the *New York Medical Record* by Dr. Robinson, in which lichen planus and lichen ruber were described as two diseases, the former being the most localized. Mr. Morris thought on the whole that lichen planus was probably neurotic and not a blood disease, as it often developed in persons who were severely depressed. He mentioned the case of a lady, aged fifty, whose husband died suddenly abroad. On her return to England she was, after a few days, attacked with general lichen planus, accompanied with intense irritation and other nervous symptoms. She gradually recovered as the depression passed off, under the influence of arsenic and complete rest. This pointed to the disease being a nerve storm like megrim, with cutaneous manifestations.

DR. COLCOTT FOX remarked that modern researches had accumulated a mass of evidence to show that the nervous system played a very prominent part in the evolutions of skin diseases, either directly through trophic nerves or through the agency of the vasomotor system. From anatomical considerations it was evident that if a morbid influence was exercised through the vaso-motor nerves, the areas occupied by the eruptions would correspond with the areas of blood supply. It was difficult to resist the conclusion that the corymbose patches of eruption seen in a great many affections of the skin were thus caused. It was still more impossible to resist the conclusion that the patches of shingles were developed on the trajectory of a nerve, and indeed this had been placed on sure ground. From the mass of evidence to hand he might point to the evidence of naevi, both blood-vascular and papillary, in relation to nerve distribution, and this brought him to speak of continuous lines or narrow bands of eruption which were usually ascribed to nerve influence though more difficult to account for at first sight. Such bands he had described in 1880 as occurring in slight asymmetrical cases of lichen planus, and these were now confirmed by Dr. Mackenzie. As to the etiology of lichen planus, he had been schooled in the theory that it was a neurosis, from the constitutional symptoms present, and his experience led him more and more to adopt this theory.

In reply DR. STEPHEN MACKENZIE said that he quite agreed with Dr. Colcott Fox as to the neurotic nature of lichen planus as had been so well pointed out by the late Dr. Tilbury Fox. The gist of his paper had been to show that the affection of the nervous system was of a general kind, but that the distribution of the eruption was not so much determined by nervous agency as was supposed. Where the direct influence of the nervous system was undoubted, the eruption tended to have an unusual or unsymmetrical distribution.

CHANCROIDAL BUBOES.

M. STRAUSS recently made an important communication to the *Société de Biologie* upon chancroidal bubo. It has been generally admitted that chancroid may give rise to a simple bubo with non-inoculable pus, and to a virulent bubo with inoculable pus.

M. Strauss examined at the Hôpital du Midi the pus of forty-two buboes originating from chancroids. These buboes were in different stages of evolution, but all containing pus. After having sterilized the skin by washing, Strauss opened the bubo, took the pus and examined it. In none of these forty-two cases did he succeed in coloring and demonstrating the presence of micro-organisms. This, in particular, would lead him to recall the conclusion which he had formulated, that there are always micro-organisms in phlegmonous pus. The *bouillons* which he had sown with this pus all remained sterile. He had, moreover, practised inoculations with this pus with negative results, even when the inoculations made at the same time with the pus of the generating chancroid gave positive results. Finally, in isolating the bubo at the moment of opening it from all contact with the chancroid by means of a disinfecting cotton and a spica, without using any antiseptic agent the buboes always behave as simple buboes—they never became virulent.

M. Strauss concludes that when the bubo of a chancroid becomes virulent, it is because the wound of incision has become contaminated by the secretion from the chancroid itself. The virulent bubo will then completely disappear when sufficient care is taken to prevent the contamination of the bubo by the chancroid which occasioned it. In a more recent communication before the *Société de Chirurgie*, M. Horteloup takes exception to the conclusions of M. Strauss. After referring to the importance of diagnosing the two forms of adenitis, the simple inflammatory and the virulent, he says that the virulent bubo has ordinarily a particular march and aspect which leads one to suspect its character, and that certain chancroids would appear to more particularly predispose to it by their anatomical situation.

But in the history of chancroidal bubo one point remains obscure. When inoculation is made at the moment of opening into the pus of a bubo, which will later become chancroidal, the result is very exceptionally positive; but twenty-four or forty-eight hours after incision or spontaneous opening, the inoculation gives a positive result.

To explain this bizarre fact, Ricord admits, in the suppurative adenitis consecutive to a chancroid, two kinds of pus; one superficial, phlegmonous, due to a peri-adenitis, the other profound, developed by the transport of the virus from the chancroid into the ganglion by the intermediary of the lymphatics; the difficulty of securing the virulent pus at the moment of the incision being the cause of the failure of the inoculation.

According to others, the virulent pus is, so to speak, overwhelmed in the midst of the phlegmonous pus, and it is necessary to await the inoculation of the entire ganglion, which being transformed into a veritable chancroid, will then produce a virulent pus.

M. Horteloup believes that there occurs in the interior of the ganglion a veritable gangrene which momentarily destroys its virulence, but which is regained after the elimination of the mortified parts.

He finds it difficult to admit the theory of M. Strauss, in the case of virulent buboes occurring in individuals whose chancroids were cured at the time of open-

ing the bubo, and when transport of the virus to the wound was not possible. M. Ricord has recorded seven such cases, and he himself had reported one.

M. Horteloup concludes that, while virulent bubo is certainly less frequent than certain statistics would lead us to suppose, it unfortunately exists.

There should be a reaction against the tendency of certain surgeons to too readily believe in the non-virulence of buboes consecutive to chancroid, and give a benign prognosis which the future course of the bubo, even when treated by occlusion, would not verify.—*Le Progrès Médicale*, Nov. 29, 1884. and *L'Union Médicale*, Dec. 23, 1884.

GONORRHOÆAL ERYTHEMA.

DOCTOR RAOUL MESNET proposes to demonstrate in his thesis: 1. That true copaiba erythemas are much rarer than have been supposed. 2. That under this name have been included a large number of cutaneous manifestations due to another cause. 3. That the greater number of these eruptions depend alone upon the gonorrhœa itself—an infectious malady.

In the first part of his thesis, M. Mesnet calls attention to the fact that copaiba has been employed in a large number of different affections without giving rise to copaibal erythema, or at least quite exceptionally as has been observed in the experiments made with it in the treatment of psoriasis. On the other hand, as Bazin has pointed out, the duration of the roseola of copaiba is by no means subordinate to that of the medication. M. Rodet, for example, has vainly continued the use of copaiba in order to maintain and prolong an eruption which he desired to exhibit. It disappeared notwithstanding the potion of Chopart, and for a long time M. Besnier, every time he meets with an eruption of this kind, does not discontinue the treatment, but, on the contrary, often increases the dose of copaiba and notwithstanding this practice the eruption disappears quite as rapidly.

In the second part of his thesis, M. Mesnet cites cases in which the eruption occurred without the patient having taken any medicine. He cites the remarkable case of M. Ballet in which a scarlatiniform eruption developed in the case of a gonorrhœal patient, with typhoid phenomena and marked febrile symptoms. An analogous case has already been published by M. Balzer. M. de Molines has also observed a scarlatinal eruption in a gonorrhœal patient who had not taken any kind of medication. From these cases, and many others of the same character, the infectious nature of gonorrhœa seems absolutely demonstrated.

These eruptions, while variable in their aspect, can only be considered as an expression of a general infection. Their most common form is a scarlatinal or rubeolic erythema, but there may be likewise observed urticaria, polymorphous erythema, purpura and furuncular eruptions: these accidents, however, do not appear to possess any gravity.

As to the physiological explanation of the production of these cutaneous manifestations, it would be premature to give it as definitive. Since, however, the existence in the economy of a special microbe of gonorrhœa seems to be absolutely demonstrated, one may ask if these dermatopathies are not the effect of the presence of these microbes in the skin, which would then become a centre of elimination of the infectious agents.—*Journal de Médecine et de Chirurgie*, Dec., 1884.

THE USE OF POWDERS.

DR. MALCOLM MORRIS thus speaks of the practice of powdering: But when a decree has gone forth that powder is to be applied to the cheeks from morning to

night to the utter destruction of the complexion, it is time to speak out, and that it does so destroy it is attested at this moment by thousands of skins puckered and pitted, that but for using powder would have remained to this day soft as silk. The constant use of powder has precisely the same effect on the glands of perspiration as the overstraining of the voice has upon the throat of a clergyman or public speaker. With the continuous exertion to secrete moisture to lubricate the throat, the glands become exhausted and give out so small a supply that, if speaking be persevered in, an obstinate complaint termed clergyman's sore throat is the result. So with the glands of perspiration in the face, as the powder dries up the moisture, more and more is secreted, till the glands become at last unable to fulfil the unavailing task, and shrinking, produce the little chasms that give the orange rind appearance that is but too familiar to all observant people. As in the petal of the flower and on the wing of the butterfly, there is always a delicate down that no powder can simulate and any excess of this is a disease.—*International Health Exhibitions Lectures*, 1884.

THE TREATMENT OF RINGWORM OF THE SCALP.

SINCE May or June, 1881 (when I was officiating civil surgeon of Backengunge, Eastern Bengal), I have been in the habit of treating cases of Indian ringworm with a solution of Goa powder in pure chloroform, painted over the patches daily. I have found this method very efficacious in curing the ringworm, though at first causing a sensation of intense burning pain (especially when applied to parts where the skin is tender, as the inner side of the thighs, scrotum, arm-pits, etc.; yet as this pain was very transient, it did not deter me from using it, and my patients did not complain. Probably a solution of pure chloroform alone would cause just as much pain if applied to tender parts. Goa powder is very imperfectly soluble in chloroform, and it is as well to shake the bottle containing the chloroform-solution well before using. I generally use a supersaturated solution. The Goa powder, or araroba, contains, according to Martindale and Westcott, eighty per cent of its weight of chrysarobin or chrysophanic acid (also see an analysis of Goa powder in the *Pharmaceutical Journal* for 1875). Since the earliest part of 1882 I have frequently used the chloroform-solutions of Goa powder for patients in the European General Hospital, and always keep a supply ready.

I think that the impalpable yellow precipitate of chrysarobin left after the evaporation of the chloroform, and which adheres pretty firmly to the skin, is infinitely preferable to the ointments and pomades containing Goa powder, which are sold in this country.—GEO. F. A. HARRIS, M.R.C.S., L.R.C.P. Lond.—*Brit. Med. Journal*, Jan. 24, 1885.

BLÉNORRHAGIC FOLLICULITIS IN WOMEN.

GONORRHOËAL urethritis and vaginitis are most frequently attended with folliculitis.

This folliculitis may persist a long time after the vagina and urethra have regained their normal condition. It is often the cause of errors of diagnosis, moreover; it often passes unperceived, and in this case the gonorrhœa remains unrecognized.

The structure of the follicles is that of glands *en grappe*. Under the influence of exciting causes, even when the vaginitis and urethritis have been long cured, the folliculitis may re-develop and propagate the gonorrhœa.

Chronic inflammation of the intra-urethral follicles may lead to hypertrophy of their elements and give rise to small polypiform tumors.

The peri-follicular cellular tissue, under the influence of a new irritation, may become inflamed and suppurate. In this case an abscess is formed. This abscess may result in fistule.

Gonorrhœal folliculitis cannot be cured by the means ordinarily employed in the treatment of vaginitis and urethritis. It is necessary to destroy the follicles locally, and this can be accomplished by an energetic cauterization, the galvanocautery for example.—DR. E. BAUCHET, *Thèse de Paris*, 1884.

CONTRIBUTION TO THE STUDY OF GUMMOUS PERIOSTITIS OF THE SCAPULA.

GUMMOUS periostitis of the scapula is circumscribed or diffuse. The latter variety is rarer than the former.

It appears in the tertiary stage of syphilis. From a clinical point of view, it presents itself under three forms: *a*, under the form of a dry guminous tumor; *b*, under the form of an abscess; *c*, under the form of osteo-sarcoma.

Gumma of the scapula consists of tumors slow in their evolution, indolent, and but slightly painful. Their volume is variable, but scarcely surpasses that of the two fists. Their development is characterized by two quite distinct phases, one of crudity, the other of softening gummous periostitis. It may undergo resolution, either spontaneously or under the influence of treatment. It may be the starting-point of exostosis, hyperostosis, or terminate in suppuration.

The scrofulous diathesis seems to favor this suppuration.

The diagnosis is oftentimes quite difficult, and demands a great perspicacity on the part of the surgeon. Gummous periostitis, in fact, sometimes presents all the characteristics of a cold abscess, of a scrofulous gumma, or of an osteo-sarcoma.

In general, specific treatment is not slow in producing the complete disappearance of the lesion.—DR. FOLLIO, *Thèse de Paris*, 1884.

THE INFLUENCE OF CERTAIN SYPHILITIC LESIONS OF THE UTERUS UPON LABOR.

SYPHILIS may be the cause of dystocia, by the alterations which it produces in the structure of the neck of the womb.

The induration which sometimes accompanies cervical chancre, which follows it, or which may occur without other local accident at the same time that crops of secondary accidents appear upon other portions of the body, is a cause of rigidity of the borders of the uterine orifice.

In these cases, where microscopical examination has been practised, the lesion was found to be constituted by a rarity of the bundles of smooth muscular fibres, and by the predominance of a dense, compact, fibrous tissue, infiltrated with lymphoid cells. It was, in fact, a chronic inflammation of the cellular tissue with chronic lymphitis.

Rigidity of syphilitic origin is easily recognized by the history of the case, by concomitant lesions, and by its objective characters.

Treatment by baths, by warm douches upon the cervix, the local application of extract of belladonna is generally without avail. Incisions of the cervix should be practised when the condition of the mother and the child indicates it.

Properly performed, the operation is generally without danger. The only death which has occurred after the incisions was not due to the operation.—DR. MESNARD, *Thèse de Paris*, 1884.

Received.

Die Stauungsdermatösen des Unterschenkels und ihre Behandlung. Von Dr. P. G. UNNA. (Reprint.)

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Psoriasis-Verruca-Epithelioma: A Sequence. By JAMES C. WHITE, M.D. (Reprint.)

Items.

SOLUTION FOR ORCHITIS.—Acide Phenique, 9 grams; Alcohol, 1 gr. Dissolve. By means of a brush dipped in this solution, the integument of the inguinal canal over the course of the painful cord should be painted three or four times with intervals of a few seconds between each application. A sharp burning results which should be allayed by cold compresses. In the case of severe orchitis with funiculitis, this painting should be repeated the third or fourth day. This mode of treatment, according to the author, reduces the duration of the affection to eight days or less. A single cauterization suffices in some cases to arrest the orchitis.—DROUET, *L'Union Médicale*, No. 140, 1884.

GRAY PLASTER (SIGMUND).—R Emplastrum Hydrarg.; Emplastrum Saponis, ã 30 grams. Melt with a gentle heat and spread upon a cloth. This plaster may be applied to tumors of syphilitic origin, upon papules, vegetations, fissures of the same nature, upon indurated testicle, etc. It may be formed into bougies or suppositories and introduced into the rectum or urethra in cases of syphilitic induration.—*L'Union Médicale*, No. 149, 1884.

IODIDE OF POTASSIUM FOR PSORIASIS.—Dr. Greene, director of the hospital in Christiana, recommends large doses of iodide of potassium in the treatment of psoriasis. The dose is gradually increased until it has reached 15 grains three or four times a day; the effect on the eruption is visible. As the dose is still further increased, the improvement is rapid. No local treatment is used.

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Original Communications.

THE RELATIONS OF SKIN DISEASES TO MARRIAGE.¹

BY

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MARRIAGE and syphilis has been so thoroughly discussed and so much attention has been paid to it, not only by syphilographers, but by the profession in general, that all the phases of the question have been considered. Despite this, all authorities are by no means united in their conclusions, although all agree that, during certain stages of the disease, marriage is entirely precluded. That syphilis is hereditary and transmissible is acknowledged by all who have had any experience whatever in the observation and treatment of the disease. Those physicians who have paid any considerable attention to insanity and affections of the nervous system, claim for many forms of the neuroses if not a direct transmission, at least a hereditary tendency to the same or allied forms of nervous lesions, derived from one or both parents. Rheumatism, gout, hemophilia, phthisis, and a number of other general affections are accused by a number of experienced writers to have that power in them by which the parent will hand down the peculiar susceptibility to those diseases, to his unlucky progeny. On the other hand, some very respectable authorities deny heredity as such, whilst acknowledging that the physical weakness is perpetuated.

A few of the more common, and at the same time most troublesome, diseases of the skin will be briefly noticed in this paper, and an attempt made to point out the probable chance of their reappearing in the off-

¹ Read before the St. Louis Medical Society. April 4, 1885.

spring, together with the reasons why patients suffering from certain dermatoses should, if not entirely give up marriage, at least postpone that relation until circumstances justify such a course. As a prefatory remark it may be stated that it is not necessary for the mother or father to be the recipient of the trouble from the consort in order that the child may be the subject of the disease.

It is not the local manifestation of the disease that constitutes the active factor, but rather the general condition of the entire economy of one of the progenitors, which has undergone certain more or less profound changes which manifest themselves more or less distinctly upon the external surface of the body, as a sort of danger signal; and, generally, there are certain appearances connected with these lesions that, to him who can read, constitute a fair index of the severity of the existing condition.

It is manifestly obvious that a person suffering from an infectious or contagious disease should not marry during the active period of the trouble. No one afflicted with any one of the parasitic diseases would object to submitting to a proper course of treatment before marrying. But there are some troubles of the skin which, although we may admit that they are neither contagious nor directly transmissible, or only rarely so, are sufficiently dangerous, in this respect, to awaken our attention and deserve more study. It will be noted that the extreme views of the French and German schools of dermatology have been avoided, as we are not willing to admit, upon the one hand, the universal constitutional nature of all dermatic affections; nor will we, on the other, concede that they are all purely local and due, almost without exception, to external causes alone. For this reason, whatever authorities we have consulted are chiefly those occupying what we consider the most rational position, which is one situated midway between the two extremes, and from those who are willing to let theory bend to facts.

The object of these few remarks is not so much to uphold a theory as to inquire whether there may not be enough in the question of the heredity of skin diseases or the predisposition thereto, to make it of some moment to the medical practitioner who may be questioned as to such being a bar to marriage.

Eczema is by far the most common, and, unfortunately, it often becomes the most intractable of the troubles afflicting the skin. When first studied the disease was for a long time regarded as purely local; then it was admitted by a large number that it might be somewhat dependent upon internal causes. Its heredity was denied *in toto* at first. We find that, later on, in speaking of the etiology of this protean disease that some authors acknowledge having seen a few—a very few—cases, which they considered hereditary. The latest work on the subject and

one which we, as Americans, are proud to point to, is Bulkley's sterling work. He says:¹ "But, on the other hand, although the disease appears to come by direct inheritance in but a very few cases, it is still true that in a certain number it is seen to be hereditary, and whole families are sometimes affected, not only in one generation but in several." . . . Again, "Scrofula or struma undoubtedly appears as a predisposing cause of eczema in the way of inheritance, quite as effectually as when existing in the individual." Van Harlingen, Piffard, Liveing, Duhring, E. Wilson, and even Neumann acknowledge that, in some cases, this disease is undoubtedly hereditary. There is also a greater probability of its being transmitted, if it exists as an old chronic and intractable form of the disease in the parent.

The next most common affection which we meet with in practice is, no doubt, psoriasis. This disease is acknowledged by all authors of any prominence to be hereditary. It is contended, however, by a number of recent observers that the heredity is more marked, or more liable to be seen, if one or both parents have had the disease in a marked and recurrent form. In those cases in which it assumes the "universal" form, it is pretty certain that the offspring of the affected parent will either exhibit the same disease, or some allied cutaneous affection.

Lupus vulgaris, whose pathology is as yet involved in more or less obscurity, is another one of these dermatic affections which would seem to be transmitted from parent to child. We will not inquire whether the neoplasm which constitutes it is scrofulous, tubercular, or of some other origin. Any one of these causes is sufficiently impressed upon the constitution of the progenitor to involve that of the progeny by direct inheritance.

Ichthyosis, especially of that variety known as "ichthyosis hystrix," is undoubtedly a hereditary affection, or, rather, deformity. There is no single author who has ever observed any number of cases, limited though it be, who has not immediately had his attention called to this important fact. It would be useless here to advert to the *dicta* of the many dermatologists who have expressed an opinion upon the subject. The disease is undoubtedly the most markedly hereditary one with which we are acquainted.

Lepra, or true leprosy, whether it be dependent upon a bacillus or not, is transmissible from parent to child. Although no well-authenticated cases exist to show that it has been acquired by contagion, or that its bacillus has been successfully inoculated, examples of its occurrence in families which have continued leprosy for several generations are numerous and well attested. Whether the primary cause be climatic or parasitic, the fact of its heredity remains.

¹ Second Ed., p. 93.

Chronic pruritus has been observed in a mother, her daughter and granddaughter, as detailed in the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, February, 1885, by Dr. Wm. J. Maynard. An interesting fact in connection with this is that the male members escaped.

Sarcoma and carcinoma of the skin are further examples—of a malignant type of disease—of dermatoses which are transmissible from generation to generation.

The writer has observed cases of vitiligo in which the trouble was transmitted to the offspring apparently. Not only was there a reappearance of the disease in the children, but all were affected in a manner similar to that of the parent, and identical parts were the first to be involved in the process.

We know well that the color of the skin is very susceptible of being transmitted to the children, and we daily observe such as the results of mixed intercourse. Each race has certain pigmentary peculiarities of the skin, which, by some process or other, seem to be stamped upon the child to a greater or lesser degree. In certain families we find that a lock of white hair in a particular locality is transmitted from generation to generation, just as other peculiarities or deformities are. Often, again, whole generations escape, and the "sign" reappears upon a remote descendant, showing that although this peculiar force may become latent, it does not necessarily lose any of its strength on that account, as all those acquainted with the facts of atavism know.

A cursory glance at these various examples would seem to indicate that heredity plays but a very unimportant part in the genesis of skin diseases. But when we take into consideration the small amount of care taken, not only to trace diseases back to their origin, but also the inability to follow the various successions through different generations, the amount of evidence offered acquires more force than would be at first accorded to it. Besides this, the cause can often be recognized as being some condition which has shown itself in different ways, and only evidence itself as a skin disease in the last member of a long line of individuals. Were our observers to pay more attention to this subject, there is no doubt whatever that the rôle played by heredity would be found to be much more important than it is regarded at the present time.

As a natural conclusion it will follow that, if certain skin diseases are directly transmissible, or if the causes thereof are, marriage between individuals affected with these troubles, whether the disease be confined to one or both of the high contracting parties, should be very carefully considered, if not prohibited. Before permitting such an union to take place, the dermatic genealogy should be carefully examined, and all the possibilities conscientiously weighed. The intention of this paper is rather to call attention to a few isolated facts, and to direct observation

to a new point in connection with the etiology of skin diseases which may prove serviceable in the prevention of a number of the most intractable and chronic affections which afflict the human skin. There is no doubt whatever that the more these relations are sought after the more often will they be found, and enable the physician to give safe and reliable advice in those cases where it will be needed or sought.

ETIOLOGY AND PATHOGENESIS OF DRUG ERUPTIONS.

BY

P. A. MORROW, M.D.

(Concluded from p. 110.)

IN studying the pathogenesis of drug eruptions, we are embarrassed by a lack of definite knowledge respecting the physiological action of drugs. Certain of these eruptive disturbances are apparently an expression of the specific action of the drug upon the cutaneous tissues, as much so as are its other physiological effects upon the general system; while the anomalous eruptions must be considered as an aberration of the drug's normal action, the deviation from the typical mode of action being determined by the forces of the organism through which it operates.

If we know little of the laws of drug action, we know still less of the laws which govern individual susceptibilities. We do know that in the antagonism between these forces, the latter is often dominant and supreme, and that the effects of drugs are especially subordinate to conditions of aptitude inherent in the individual. Leaving out of consideration for the present that mysterious factor expressed by the term idiosyncrasy, let us examine the various theories which have been put forward as to the mechanism of the production of these eruptions.

In the first place, it may be said that an explanation of these incidental cutaneous phenomena has been sought for in the *quality of the drug*. It was naturally inferred that the production of unusual drug effects must be caused by an impurity of the agent used, due to its faulty mode of preparation or its accidental admixture with toxic principles, etc. With this view, other preparations of the same drug have been substituted, the alkaloid for the crude drug, and *vice versa*, with the result of the production of identical irritant effects upon the skin. So that the assumption of a possible impurity of the drug as the efficient cause of these irritant effects upon the skin must be dismissed as groundless and disproved by careful experimentation.

The theory which has been adopted by most writers on this subject is, that a large proportion of these eruptions are caused by the elimination of the drug through the skin.

The theory of the elimination of drugs through the cutaneous glands is based upon the assumption of the existence of one of two conditions as determining causes: 1. Impairment of the integrity of the eliminating organs. 2. Elective affinity of the drug for the constituent elements of the glands.

The hypothesis of the impairment of the integrity of the eliminating organs as a determining cause, is based upon the view that since almost all drugs introduced into the system are normally eliminated by the kidneys, when from any cause this channel of egress is blocked up, the skin by virtue of its vicarious functions attempts to perform the work of the kidneys, and the drug in its passage through the cutaneous glands causes irritation, which is manifested by various lesions. This theory, which has been urged with some plausibility by Farquharson, seemed to gain support from clinical facts. Several cases were cited in which the use of the bromides and iodides caused severe cutaneous disturbance and the patients were found suffering from renal inadequacy and cardiac lesions. But further clinical inquiry has not demonstrated a relation of cause and effect between severe renal disease and a special liability to a determination of drug action towards the cutaneous surface, even where the pathological alterations were of such a nature as to incapacitate these organs for the proper performance of their functions.

This theory pushed to its legitimate conclusion would attribute all drug eruptions to cumulative action, on the principle that introduction should in all cases be compensated for by elimination—the maintenance of this equilibrium being the condition of normal drug action. In other words that “saturation of the system” with a drug must occur as a preliminary or necessary condition of the production of its incidental effects.

This assumption is, however, abundantly disproved by clinical facts. We find that the smallest dose of a drug will, in many individuals, promptly produce the most violent tegumentary disturbance, while in others, massive doses of the same drug may be continued during long periods with absolutely no effect upon the cutaneous surface, the result being entirely independent of the *quantity* of the foreign element circulating in the blood. In the analogous cases of eruptive disturbance *ab ingestis* we recognize that it is the quality, not the quantity, of the irritant that offends.

Another phase of the “saturation of the system” theory is that the foreign material accumulates until nature, unable longer to tolerate its presence, concentrates her forces and makes a grand parturient effort to expel the offending material through the cutaneous pores, and in this

process the skin suffers various lesions of continuity. This theory is akin to the now obsolete one which recognized in the roseola of syphilis, and the exanthem of the specific fevers, an evidence that the poison had been driven to the surface and was in process of expulsion.

The second hypothesis is that drugs have an affinity for special anatomical elements, and that, by virtue of this selective action, certain drugs are attracted towards the cutaneous glands. Physical and chemical evidence of this pathogenetic mode is furnished, it is claimed, in the anatomical seat of certain lesions, as the sebaceous glands in iodic and bromic acne, and in the demonstrated presence of the drug at fault in the lesions which it has caused. No absolute proof that either of these conditions is a constant occurrence has been adduced. While the follicular apparatus may be incidentally involved in any morbid process affecting the skin, there is no evidence that it is the exclusive seat of these lesions.

On the contrary, careful and minute investigations into the anatomical seat of iodic and bromic lesions have shown conclusively that, in many cases at least, the sebaceous glands were unaffected. Drs. Thin and Duckworth concluded from their investigations of iodine lesions that they were not of the nature of acne; microscopical examinations showed no implication of the sebaceous glands and hair follicles. Negative evidence is also found in the fact that these lesions occur in cicatricial tissue, and in regions where sebaceous glands do not exist. Other observers have furnished positive proof that these lesions are of the nature of a localized dermatitis, in which the glandular structures may be healthy, or only incidentally involved.

Proof of the second proposition is sought for in the fact that the drug has been found in the contents of certain lesions, detected in the act, so to speak. But absolute proof of the production of these lesions in this way cannot be adduced. So far from being a constant phenomenon, we are justified in regarding it as a mere accident or coincidence, since numerous observers have failed, even with the most carefully conducted tests, to detect the presence of the drug in the cutaneous lesions, while it was freely found in the urine. If the elimination of the drug through the glands be the cause of the disturbance, its presence should be a constant feature. Again, if the matter were reduced to a simple chemical combination between a certain drug and the glandular elements, then this action should take place every time and in every case where these two factors were brought into contact. On the contrary, instances are exceedingly rare in which such a reaction could by any possibility be alleged.

Trousseau sought to establish an identical pathogeny for sudoral and drug exanthemata, claiming that both were caused by a modification in the composition of the sweat, which took on an irritant quality, and in its

passage through the cutaneous excretories, betrayed this irritation by a variety of pathological lesions. But proof that these lesions are not caused by an irritant and exaggerated sudoral secretion is found in the fact that two drugs, opium and belladonna, both produce a scarlatiniform eruption. The specific action of one is to stimulate the functional activity of the sweat glands, while that of the other is to diminish or suppress this function altogether. Further proof that eruptive disturbances are independent of the functional activity of these glands is furnished by the fact, that the existence of the condition known as unilateral sweating does not modify the symmetrical development of a drug exanthem. In a number of such cases reported, there was no difference in the rash on both sides.

Admitting that the eruptive disturbances which follow the ingestion of certain drugs are the result of modifications in the glandular tissues, associated with increased functional activity, we see in this only an evidence of the direct influence of the drug upon the special nerves which regulate the secretory functions of these glands. Recent physiological research has demonstrated the existence of special secretory fibres, which are distributed to the salivary and sweat glands, and which regulate their functional activity independent of conditions of hyperæmia. It has been conclusively shown by Sartisson that the absorption and elimination of iodine by the salivary glands, for example, is due "not to chemical affinity of the drug for the substances of which the gland is composed, but to nerve influence alone," so that either functional or structural changes in the sweat glands point to a disordered innervation, the determining cause of which must be sought for in the action of the drug upon the special nerves which supply these glands.

The "elective affinity theory" must therefore be dismissed as improbable. There is no evidence that the cutaneous glands or other tissues of the body exert any influence upon drugs which is at all of the nature of attraction.

Behrend classes drug eruptions under the title of "Hematogenetic Exanthemata," on the theory that they are for the most part due to changes in the blood susceptible of clinical demonstration. He assigns special prominence to what may be termed the dynamic theory. He asserts that all drug eruptions, with the exception of the erythemas caused by the specific action of belladonna, hyoseyamus, stramonium, and perhaps arsenic, and the acneiform and pustular eruptions commonly seen after the use of the bromides and iodides, more rarely after arsenic, are caused by the dynamic action of drugs. This effect, he claims, is entirely independent of the physiological and therapeutical action of the drug, but due to the agency of a foreign material, probably of chemical

nature, generated in the blood by reason of the presence of the drug in the system.

Whether this foreign material is produced by catalytic action or the result of direct combination with the drug with a hypothetical substance in the blood is not specified. It is singular that this mysterious clinical compound should be so potent for mischief and yet so indefinite in substance that its detection transcends our powers of analysis. This hypothesis seems as fanciful as it is utterly untenable. It is merely a modification of the old humoralistic view which attributed all pathological alterations to a dyscrasic condition of the blood. Besides, this theory is irreconcilable with clinical facts. If the changes in the skin be caused by a changed blood mass, they should not be confined to restricted localities, as is often the case, but should be manifest everywhere the blood circulates.

We come now to a consideration of the theory of the neurotic origin of drug eruptions—a theory which recognizes the intimate dependence of all cutaneous changes, whether slight and transient, or more profound and persistent, upon disorders of innervation.

While, at first glance, it may appear inconsistent to group together eruptions so multifarious in form and character, and attribute the same pathogenetic mode to drugs widely varying in their physiological action, yet there are many considerations which force us to the conviction that it is in the sphere of the nervous system that we must look for an explanation of these phenomena. In the light of our present knowledge respecting the primary action of most drugs upon the nervous system, such a pathogenesis of these eruptions is not only conceivable, but, reasoning from analogies with other cutaneous phenomena the neurotic origin of which has been demonstrated, it appears extremely probable.

In studying the symptomatology of drug eruptions, we find that a large proportion present the characters of simple cutaneous congestions, associated with sensory disturbances more or less severe. Usually the nervous symptoms precede the development of the exanthem.

These congestions appear suddenly, and may affect only certain cutaneous regions, or they may become generalized, according as the disordered innervation is limited to particular vascular areas or affects the entire cutaneous vascular system. The character of the changes impressed upon the skin will depend upon the blood-stasis, whether it be transient or prolonged and intense.

In some cases, no doubt, these congestions are purely reflex phenomena, the point of departure of which is irritation of the sensory nerves of the gastro-intestinal mucous membrane. They are analogous to urticaria ab ingestis, and reflex changes in the skin from irritation of a peripheral nerve, as in traumatism. Besnier attaches considerable

importance to this pathogenetic mode, and proposes to circumvent it by introducing the drug hypodermically. Unfortunately for this theory, it has been proven that the dermatopathic effect is, in the case of most drugs at least, entirely independent of the mode of their introduction into the economy. It is probable that irritation of the terminal filaments of the pneumogastric accounts for but a small proportion of these cutaneous disturbances.

The large majority are consecutive to absorption of the drug, and due to its specific action upon the peripheral nerves or nerve centres. Whether this influence be exerted primarily upon the vaso-dilator or the vaso-constrictor nerves, the ultimate effect is vascular dilatation, and if the congestion be sufficiently intense, exudation. We recognize the erythematous and urticarial eruptions of arsenic, belladonna, bromide of potassium, chloral, copaiba, digitalis, hyoseyamus, opium, morphia, quinine, stramonium, salicylic acid, etc., as angio-neurotic phenomena, caused by the specific action of the drugs in question upon the vaso-motor system.

The similarity in these eruptions to other cutaneous phenomena, the nervous origin of which is recognized, would argue similarity of pathogenetic mode. It is now accepted that the roseola of syphilis, the prodromal rash of variola, the exanthem of measles, scarlatina, typhoid fever, etc., are due to the direct action of an irritant, the specific virus of the particular disease, upon the centres which preside over vaso-motor innervation. We may reasonably infer a like nerve influence in the production of erythemas from drug action. The assertion made many years ago by Wilson that "the influence of the vaso-motors are involved in the production of all roseolas," may be extended to embrace all cutaneous phenomena of a simple congestive character.

The more fugitive forms of drug hyperemias present many striking analogies both in form and localization with that large class of eruptions known as mental or emotional congestions, doctor's rash, which is so constant a phenomena in the examination of nervous females, *erythema pudoris*, etc. These are pure angio-neuroses dependent upon an impression emanating from the emotive centres.

Clinical analogies with drug eruptions may also be found in traumatic, septicæmic, and menstrual eruptions, the *taches cérébrales*, tabetic ecchymoses, etc., occurring in cerebral and spinal diseases, and which are absolutely inexplicable except on the theory of their neurotic origin.

We have seen that in many cases the severer forms of eruptive disturbance are the outgrowth of the simpler, the grade of the eruptive element depending upon the continuance of the morbid stimulus. There are certain other cases, however, in which the eruption is only developed after the more or less prolonged use of the drug, the structural changes having a definite relation to the size and continuance of the dose, such

as the severer forms of the bromide and iodide eruptions, for example. The changes in the skin are often associated with the profound systemic effects of the drug, known as "Iodism," "Bromism." In these cases, in addition to the vascular pathological phenomena, there are nutritive or trophic modifications.

While there is no doubt that the vaso-motor nerves modify to some extent the nutrition of the tissues to which they are distributed, yet in these severer forms, characterized by a disturbance of local nutrition more or less profound, another agency than vaso-motor innervation is apparently involved—they are probably due to an impression of the drug upon the trophic centres which regulate nutrition.

Physiological research, as well as pathological facts, have demonstrated that the nervous system exercises a constant and controlling influence upon the nutrition of the tissues. Whether this influence is exerted through the nerves which regulate vascular supply, or whether there exist certain nerves with specialized functions which have been denominated trophic nerves, is immaterial to our present inquiry. The fact remains that a trophic influence is exerted upon the cutaneous tissues by the nerve-centres, and that when any impression disturbs this regulating power, perversions of nutrition result. This disturbing impression may be made upon the nerve-centres or upon the peripheral nerves. Peripheral irritations will cause reflex alterations of nutrition precisely as they cause reflex disturbances of motor functions.

The direct dependence of cutaneous lesions, varying in character and intensity from simple dermatitis to the profoundest changes in the skin and cellular tissue, upon alterations in the peripheral and central nerves, has been demonstrated by numerous anatomico-pathological investigations. The neuropathic origin of pemphigus, zoster, leprosy, symmetrical gangrene, decubitus aentus, mal perforans, ulcers of the leg, exfoliative dermatitis, and certain cases of eczema have been thus demonstrated. May we not reasonably infer a like pathogenesis in the case of drugs which are capable of exercising such a profound influence upon the nervous system?

The fact that structural alterations of the nerves, leading in many cases to abolition of their functions, have been found in the diseases just referred to, does not militate against this view. Physiological experiments have proven that molecular changes in the nerves, from excitations of transient influence, electricity for example, affect the nerve functions precisely as do gross pathological changes of structure, or even section of the nerve.

While there is no positive evidence that drugs produce modifications of molecular arrangement, however minute, in the nerve tissues, yet it is a noteworthy fact that a large proportion of the medicinal agents which

determine eruptive disturbances, act specifically upon the nervous system. Many drugs not credited with this physiological action undoubtedly exercise it. Proof of this proposition is found in the neuropathic character of the several groups of symptoms comprehended under the general terms, "iodism," "bromism," "cinchonism," "hydrargyrisms," etc., with which the irritant action of the drugs upon the cutaneous surface is so often associated. All authorities recognize these manifestations as due to a disorder of the central nervous system, caused by the depressant action of the drug upon the brain and spinal cord. If the impairment of sensation of mucous membranes, formications, muscular tremors, troubles of intelligence, parietic phenomena, and other grave symptoms of "bromism" be manifestation of the effects of the drug upon the nerve centres, why is not the concomitant "bromic acne," with which these symptoms stand in intimate connection, likewise a neurotic phenomenon? It is irrational to separate the skin affection from the group of other symptoms which make up this clinical picture, and assign to it an entirely different pathogenesis.

In concluding this study of the pathogenesis of drug eruptions, it may be said that the only correct interpretation of the physiological predisposition, known as idiosyncrasy, as a determining cause is based upon a recognition of their neurotic character. This conclusion may be derived from the presentation of the problem in the form of a syllogism, thus: Drug eruptions are determined by idiosyncrasies. Idiosyncrasies are neuroses; therefore, drug eruptions are neuroses.

Without considering possible objections to the validity of the premises, or the logical character of the deduction, we may safely assert that so far as we can apprehend the nature of idiosyncrasy, as affecting the cutaneous action of certain drugs, it seems to depend upon a heightened susceptibility of the nervous system, associated or not with a specific predisposition of the cutaneous tissues to irritant impressions. In persons who manifest this idiosyncratic intolerance, the equilibrium existing between the skin and the nervous system in their vascular and nutritive relations is easily disturbed, the form and intensity of the resulting reaction being largely determined by the physiological properties of the tissues affected.

As is well known, the incidental effects of drugs may be manifest in other organs. The explanation of their more frequent determination toward the skin must be sought for in the sympathetic lines which unite the nervous and cutaneous systems. The skin is not only the receptive surface of all sensory modifications from the external world, but it is the principal medium through which the nervous system manifests its emotional and other disturbances.

Proof of the neurotic character of drug eruptions may also be drawn from

the alterations of sensibility, with which they are associated ; their symmetry ; their generalization or their restriction to certain regions, according as the drug affects the general nervous system, or the special nerve centres which preside over particular cutaneous departments. Indeed, their very caprices and contradictions constitute a strong proof of their neurotic origin, suggesting a modification of the controlling, regulating influence exercised by the nerves upon circulation and nutrition.

PERI-URETHRAL ABSCESS. RUPTURE INTO THE URETHRA. COMPLETE CURE.

BY

JOHN WARREN, M.D.

THE following history is an interesting one, on account of the rapid closure of a urethral fistula, caused by a peri-urethral abscess complicating a case of gonorrhœa :

I was consulted on July 23, 1884, by a young man, 28 years of age, who gave the following history : Two weeks previously he contracted gonorrhœa, for which he did not at once seek medical advice, having had several previous attacks. He commenced the use of copaiba capsules as soon as he noticed the discharge. Several days before seeing me, he noticed a small lump on the penis, just behind the glans, on the right side, which gave no pain ; but as it increased in size daily he came to me to learn its cause. On examination, I found a swelling about the size of a pea on the forward end of the corpus cavernosum, one inch behind the corona glandis, on the right side, adjacent to the upper part of the urethra. It was hard to the feel ; little or no tenderness on pressure ; no fluctuation ; no surrounding induration.

There was a moderate discharge from the urethra, some ardor urinæ, and his general condition was very poor. He was anæmic, and complained of having no appetite and losing flesh for the past week.

I diagnosed a peri-urethral abscess, put him upon tonic treatment, also an alkaline mixture. I saw him again in a day or two, at which time the abscess was a little larger, the gonorrhœal discharge about the same, but the general condition of the patient was better. I decided to make a free opening of the hard mass, which I did the next morning. On making a deep incision, a few drops of pus were evacuated, and on introducing a probe a small cavity was distinctly felt in close proximity to the urethral wall. A small tent of lint was introduced into the cavity,

and a poultice applied for twenty-four hours, during which time there was a free discharge. For several days after the opening remained well established, and continued to discharge. The tent was removed several times during the day, and a few drops of the balsam of Peru injected. Four days after the abscess was opened the patient had to leave town, during which time the external opening closed. Shortly after this he felt more pain than usual about the spot, also noticed some return of the swelling, and that the discharge from the urethra, which had been growing less, increased in quantity. A small probe was at this time with difficulty introduced into the sinus, but the opening was so small that it allowed no discharge to pass through it. The next day a small pustule made its appearance about one-third of an inch from the original opening, which ruptured immediately and discharged some pus.

I found, upon introducing a probe, a sinus which connected with the first one some distance from the surface, and upon injecting a few drops of balsam of Peru, it made its appearance in a few minutes at the meatus, together with a few drops of pus, showing that the abscess had ruptured into the urethra, probably at the time when he allowed the external opening to close. I established free drainage at once by converting the two sinuses into one, and thereby gave the abscess free external drainage and a chance to close by granulation, hoping that the urethral opening might close and avoid a troublesome fistula. The discharge through the external opening being re-established, that through the meatus diminished. The balsam of Peru no longer passed through the urethra upon being injected into the abscess, and there was every reason to believe that the urethral rupture had closed after free external drainage had been established. About this time another small swelling made its appearance just behind the "frænum preputii," on the same side as the first, rapidly followed by a third just beside it.

Dr. P. A. Morrow saw the case with me at this time, and advised incising them at once, which I did. From this time the patient improved, the gonorrhœal discharge gradually ceased, the incised wounds closed by granulation, his general condition continued to improve, so that by October 1st, the induration had been completely absorbed. There was a small stricture formed during cicatrization of the internal rupture of the urethral wall. A gleet remained, which disappeared after the passage of sounds.

Peri-urethral abscess with gonorrhœa is rare; it usually accompanies or results from stricture of the urethra. They are found at any point along the urethra, but usually near the frænum, beneath the fossa navicularis, or back near the bulb, at the peno-scrotal angle.

By some the seat of these abscesses are considered to be in the lacunæ, which rupture externally, leaving a fistulous opening; or they may

break into the urethra, but others think these abscesses begin in the connective tissue surrounding the urethra, as they do not impede the passage of the urine.

The rational symptoms, which vary with the size, number, and situation of the abscesses, are rigors, fever, loss of appetite, sometimes dysuria and severe constitutional disturbances. These abscesses are very apt to recur with succeeding attacks of urethritis, especially with decidedly acute cases, or where the patient has neglected himself or the treatment. We find that they rupture externally or internally; if the latter, infiltration and sloughing are apt to result.

A urinary fistula is more frequent near the bulb than at the glans; sometimes even when opened externally, we may have an internal rupture, as in the above case.

The treatment of this complication of gonorrhœa consists in free incision of the mass down to the urethral mucous membrane; this may be done before suppuration has occurred, or if in the perineum, we may wait for signs of pus. If the abscess occurs in the prostate, it usually opens into the urethra, or is opened during catheterism.

After the abscess has been opened and evacuated, free drainage should be maintained, and the abscess allowed to granulate from the bottom. If a fistula remain, it may, in rare instances, close, as was the case with my patient; if, as commonly occurs, the fistula refuses to close, surgical means must be resorted to.

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DERMATOLOGICAL NOTES.

BY

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New York.

I WOULD like to second the suggestion of Dr. Hardaway (in the April number of this JOURNAL) that the editors publish a series of "Dermatological Notes," by different writers. By so doing they would bring to the notice of the profession in a most concise form a large and valuable amount of instructive matter. Many therapeutic suggestions, clinical observations, and items of dermatological interest remain unpublished because they fail to make an "article" of conventional length. Or, on the other hand, they are sometimes published and the requisite length of the article obtained by a sacrifice of time and patience on the part of the reader.

Elephantiasis of Forearm and Hand.

In Waring's statistics of elephantiasis (quoted by Tilbury Fox) the disease affected the upper limb in but four cases among nine hundred and forty-five. This fact leads me to report briefly the only case of the kind which I have ever seen, and the only one, perhaps, which has ever been observed in this country.

Mrs. —, aged 46. A rather spare woman in average health. When quite a young girl, her left hand used to become red and swollen once or twice every year and resume its normal size and appearance. As she grew older, the attacks became more severe and were usually accompanied by a marked chill and fever. The swelling now would not entirely disappear as at the outset, and the hand and forearm gradually became enlarged. This condition has existed for at least twenty years. Twelve years ago, a palmar abscess formed, was lanced, and resulted in a slight flexure of the thumb upon the palm. Just before the attacks, which appeared to be of an erysipelatous character, the patient sometimes experienced a pain in the limb which extended above the elbow. Examination showed the skin of the left hand and forearm to be thick and firm in character, and somewhat dark in color from an imperfect circulation. The surface was dry, harsh, and slightly scaly. There was no sensation of pain or itching, and the patient could use the hand readily, although it was somewhat stiff and awkward. The comparative size of the upper extremities is shown by the following measurements taken at the wrist,

middle of forearm, hand, and index finger: *Right*, 6, $7\frac{1}{2}$, $7\frac{1}{4}$, $2\frac{1}{2}$. *Left*, $7\frac{1}{2}$, $8\frac{1}{2}$, 8, 3.

A decided improvement, according to the patient, followed the daily inunction of the oleate of mercury (5%). In the morning the hand would be quite limber, but the pressure of blood would soon cause it to become stiffer and duskier in hue.

Zoster Occurring in Pregnant Mother and later in Child.

A male child of five months was recently brought to the Skin and Cancer Hospital with a well-marked zoster of the right upper extremity. The patches extended from the sternum and scapular region along the inner surface of arm and front of forearm, over the palm and to the tip of the middle finger. Small vesicular patches were also noted on the posterior surface of both middle and ring fingers. The mother of the child stated that at about the fourth month of pregnancy she had a patch of similar eruption upon her right thigh, and that with a previous pregnancy she also had the eruption at nearly the same point and at about the fourth month. She seemed positive that the eruption which had appeared upon her thigh was exactly the same as that upon her child, stating that the patch on each occasion was red and "covered with groups of yellowish heads," and that it disappeared in two or three weeks without treatment. The former child has never had zoster.

I believe this is the youngest patient in which I have ever observed the disease. As to any relationship between the eruptions of mother and child, I will leave the reader to draw his own conclusions.

Inherited Keratosis of Palms and Soles.

A callous condition of the palms and soles, independent of external causes, is somewhat rare. Recently I have had several members of a family under my care, whose cases have illustrated the inherited tendency to this condition. Mr. J. came to me with a thickened yellowish horny appearance of the palms which had existed since infancy and which he had only kept from getting worse by the daily use of pumice-stone. In the natural creases of the palms and soles the epidermis was thinner and slightly powdery. Elsewhere the skin was normal. He perspired very freely even where the epidermis was thickened. According to his statement, which I had the opportunity later of partially verifying, his mother, and maternal grandfather, an uncle, a brother, two sisters, and two little nephews, were all similarly affected. His mother had eight children, and it was a noteworthy fact that every second one inherited this dermal peculiarity.

Another patient with a somewhat similar condition of the palms and soles presented a well-marked keratosis pilaris of arms and thighs and a

general ichthyosis of a mild type. His father was also affected with keratosis of palms and soles. It will be noted that this patient exhibited on his own person three peculiarities of epidermic growth, which are intimately related in their pathological aspects, but which are commonly described in the text-books as distinct diseases.

The Best Method of Removing Comedos.

Numerous little instruments have been devised and used by both physicians and patients for the extraction or rather the expression of comedos. Most of them seem poorly adapted to the purpose. For many years I used a silver tube, with a carefully rounded extremity, which certainly possesses advantages over the watch-key so frequently employed by patients and the various comedo-extractors sold by instrument makers. I am now convinced that a small, narrow, and deep curette (modelled after the hull of a canal-boat) is the best instrument that can be employed for pressing out the sebaceous plugs. The use and the value of the curette as a scraper in cases of acne and comedo is well known, but its use for the purpose of pressing out the comedos, with the least injury to the skin, I believe to be novel. Whoever acquires the "knack" which is necessary for its successful employment will not care to use anything else. When used, the beak of the curette should be gently pressed upon the skin at one side of the comedo, the handle being almost at a right angle with the cutaneous surface. Now, by a sudden and *quick* revolution of the handle between the thumb and forefinger, the result is accomplished. A slight pressure has been exerted successively on all sides of the comedo, and the white cheesy worm is usually found lying in the hollow, rounded end of the curette. A convenient vest-pocket instrument for use in cases of acne has been made for me by several instrument makers of this city. It consists of a tubular handle to the ends of which are screwed a curette such as I have described and an ordinary acne lance. When not in use, the instruments are reversed and screwed within the handle.

The Iridio-platinum Needle in Electrolysis of the Hair Papilla.

In the "Dermatological Notes" of the April number of this JOURNAL, Dr. Hardaway states that he has been casting about for many years for some needle that would effectually meet the requirements of the operation for the removal of superfluous hair. The needle composed of iridium and platinum of which he now speaks highly is by no means a novelty in New York. It was first used by Dr. Piffard about ten years ago, and mentioned by him in his book ("Diseases of the Skin," 1876, p. 307).

My own preference is for a fine *flexible* steel-needle, such as can be

obtained of various sizes and at an almost nominal cost from any wholesale dealer in jeweler's supplies. The fact that I have employed such a needle in the treatment of more than a hundred cases of facial hairiness, in some cases removing several thousand hairs, is the best recommendation I can give it. In fact, I would not wish for anything better.

A Rat-Bite of the Penis.

A few years ago, Mr. —, a married gentleman, living out of town, was engaged in business in the lower part of this city. One day, upon returning from his lunch, a call of nature led him to seek the seclusion granted by the subterranean apartment of his mercantile building. The privy, here in use, was of rather primitive construction, being connected with the sewer-pipe without the intervention of a basin, and rats had frequently indicated their presence in the walls of the premises. While Mr. — was sitting and quietly enjoying that contemplative mood which naturally steals over one in this form of post-prandial siesta, he was suddenly startled and forced to bounce from his seat in a manner most hasty and undignified. Blood was dripping on his pants from a fresh wound of the penis. It required a full moment to take in the situation when, with a suspicion that he had been bitten by a rat and a confused notion of possible results, he rushed for medical aid.

When I examined him shortly after the occurrence, I found on the left side of the sheath of the penis a loss of substance three-fourths of an inch in length which had evidently been produced by incisor teeth or some other sharp, cutting instrument. The wound, still bleeding, was cauterized with fused nitrate of silver, and the fears of the patient were gradually allayed. The wound healed quickly, leaving a superficial scar. In a note received a few weeks later, the patient remarked that, although a rat-bite might not be dangerous, the inconvenience of its presence on such a portion of the body could not be overestimated.

There is a moral to this story. A week after the bite occurred, the wound looked very much like an ordinary chancre. Now what would the reader say if a respectable married man were to come to him with an apparent chancre of the sheath of the penis and state that he had had no illicit intercourse, but had been bitten by a rat?

This story teaches that the physician who disbelieves in the vicious nature of the water-closet in connection with venereal disease might, in an exceptional case, be unwarrantably incredulous.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

153D REGULAR MEETING, MARCH 24, 1885.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. FOX presented two cases of

SYPHILIS MODIFIED BY ECZEMA.

The first patient, a German, about 50 years old, has had syphilis extending over a period of twenty-eight years. His wife has had five miscarriages. The eruption on the hands and fingers first made its appearance twenty-five years ago. When first seen by Dr. Fox the patient had a well-marked verrucous eczema of the hands, the moist discharge proving that the lesion had some of the elements of that disease.

Now he has an eruption on the wrists, hands, and fingers, the lesion presenting the appearances of a characteristic syphilide made up of discoid patches, which have a tendency to run together. These patches heal in the centre, and spread at the edges. They have well defined margins. On the hands and fingers are several such orbicular patches, tubercular in character. The nails of the right hand are discolored, very thick and brittle. Dr. Fox, when he first saw the case, believed it to be an eczema engrafted on a syphilide. He first gave acetate of potash internally, and soothing ointments were applied for several weeks with only slight benefit. When the mixed treatment was given and ammoniated mercury ointment applied, the patches healed in the centre, leaving a well-defined ring of diseased tissue around them. He remained away for six weeks, without treatment, when the eruption reappeared. Lately he has been treated locally by means of rubber gloves and a solution of salicylic acid in castor oil.

The second patient has had the eruption over a year. She has a chronic infiltrated eczema extending over the knuckles as well as the back and sides of the hands. The eruption also exists on other parts of the body. The lesion on the back of the hands presents an orbicular, scalloped margin, which to him (Dr. Fox) was an indication that the disease was modified by syphilis. He had always been of the opinion that syphilis did not modify other skin affections, but in view of the cases just presented and others that he had seen of late, he had changed his views on the subject. The patient was now taking acetate of potash with colchicum, and as yet there had been but slight improvement.

DR. KEYES thought that the first case presented evidences of a syphilitic nature in the isolated patches on the arms and the circinate spots on the hands. It also had an eczematous appearance. The scalloped and irregular edges that Dr. Fox drew attention to had often been observed by him in cases of gouty eczema. It certainly was an eczema implanted on a syphilide.

He considered the second case an eczema and did not see any evidences of syphilis present.

DR. MORROW said that he agreed with Dr. Keyes in his views as to the nature of the lesions present in the two cases. He would take exception to the remarks made by Dr. Fox that the treatment employed would determine the nature of the disease; viz., if the lesion disappeared or even improved under the mixed treatment that it was necessarily a syphilide. He remembered having shown two cases to the Society some few years ago, for diagnosis between eczema and

syphilis. He said that it was curious to note the change in opinion from one meeting to another as to the nature of the lesions. The patient was put on a treatment for eczema without producing any marked effect, afterward to test its syphilitic nature mixed treatment was employed and mercurial plaster applied with the result of aggravating the symptoms. He had seen many cases of frank eczema that presented appearances similar to those seen in the lesion affecting the first patient. He did not think that the treatment test would always positively determine the diagnosis in cases of suspected syphilis.

DR. SHERWELL was inclined to agree with Dr. Fox in regard to the diagnosis, etiology, and basis of treatment employed in the first case. He believes that syphilis modifies eczema.

He considered the second case to be one of eczema.

DR. JACKSON said that when he saw the first patient at the clinic for the first time, the lesion presented all the appearances of a verrucous eczema, but when he saw him at a later period he had no hesitation in diagnosing it as syphilis.

The second case had many of the characters of syphilis, especially the orbicular margin on the back of the hands.

DR. BRONSON thought there was no doubt but that an eczema and syphilis could be in juxtaposition, especially in a person with an eczematous diathesis. There must, however, be positive evidence of syphilis, which did not exist in these cases, although there was a well-defined border to the patches. In these cases, however, we do not find a multiplicity of lesions, an irregular distribution, or an infiltration at the margins of the lesions, all of which are present to a greater or lesser degree in syphilis. He would not call these cases syphilides. We often meet with cases of eczema with orbicular edges occurring in patients who have an arthritic diathesis.

DR. ROBINSON said that in his experience there was no reason to believe that syphilis at any time altered or modified an eczema. Syphilis always spreads toward the periphery, but he could not understand why a catarrhal inflammation of the skin, such as an eczema, should spread in that way simply because the person had syphilis. He would agree with Drs. Keyes and Morrow that it was almost impossible to make a diagnosis between eczema and syphilis.

In the second case, he failed to see any evidence of syphilis. There is nothing uncommon in the scalloped border that the eruption presents; it is often seen in rheumatic or gouty patients.

DR. KEYES said that whether syphilis modified an eczema or not, it was a well-known fact that often when fractures do not show signs of uniting, if the patient be put on an anti-syphilitic treatment, the bone unites, although there may be no evidence of syphilis. He believed that patients with eczema, especially those whose health had run down, often improve under the mixed treatment. He does not know how it acts, whether there is something in the diathesis of the patient, or simply because of the tonic effect of the medicine.

DR. PIFFARD believed that when a person spoke of a syphilitic taint without stating whether the disease were syphilis or not, that it was the resource of ignorance; either a patient has, or has not, syphilis. He had seen eczema, psoriasis, and lupus in persons affected with syphilis, but had never seen syphilis modify any other eruption. He cited a notable instance of a man who had an ulcer of the ankle, the result of an accident; he (Dr. Piffard) treated it with balsam without any benefit until he discovered a chancre in the process of healing. Here, then, was an ulcer occurring after acquiring syphilis, but before the appearance of the secondary manifestations of the latter disease. The patient was placed on anti-syphilitic treatment, and the ulcer immediately healed.

DR. FOX, in concluding the remarks, wished to say that for some years he had taught and argued that syphilis never modified any disease of the skin, but in the last year or so he had met with and studied a series of cases such as those now under consideration, and had reason to change his mind. He agreed with Dr. Robinson that it was difficult to make a diagnosis from the configuration of the lesion, but there was something in the appearance of the skin that he could not describe which led him to form a conclusion. With regard to making a diagnosis from the treatment employed, he, in the main, agreed with Dr. Morrow; but in the case where the eczema treatment failed to produce any beneficial results, and afterward when the mixed treatment was employed the lesion suddenly disappeared, he thought he was justified in believing it to be syphilis. If there

had simply been an improvement, he would not consider it an indication that syphilis was present.

DR. FOX then showed a case of

DERMATITIS HERPETIFORMIS.

The patient has had the present eruption for the past six years. When seen for the first time a few weeks ago, the patient had a number of vesicles on the side of the face. She has had the eruption all over the body. The lesion is slightly pruriginous, and is what some would call a pruriginous pemphigus.

DR. ROBINSON presented a case of

LUPUS ERYTHEMATOSUS.

Mrs. L., 45 years old, had small-pox when a child, but no lesion of the skin, with that exception, until four years ago. At that time she had an eruption which commenced on the right ala of the nose, and spread on both sides of the face, and for a short distance on the shoulders. It remained about nine months, itched slightly, was unaccompanied by a discharge, and left no scars. Two years ago the lesion returned, commencing on the forehead and extending down the side of the nose to the cheeks, involving the jaws and ears. The eruption is the same on both sides of the face; it has been on the forearms about two months. On the left side the patches vary in size from a pin-head to several inches in diameter. They are red, somewhat elevated, sharply defined, and covered with a few firmly adherent scales. There are no signs of exudation on the free surface. One of the patches is slightly elevated toward the margin, but more depressed in the centre, and is covered by a few flat, thin, firmly adherent scales. The ear is somewhat thickened, there are no fissures. No atrophy over the site of the former eruption. In some places the patches are even depressed at the margins. On the forearms there are from fifteen to twenty spots from the size of a pin-head to that of a bean; there is one irregular patch five or six times larger than the others. There are no acuminate papules. The peculiar feature of this case is the absence of scarring over the site of the former eruption.

DR. BRONSON exhibited a case of

SEVERE PRURITUS.

The patient, a woman, 21 years old, has had the present eruption for over ten years, being worse in winter than at any other season. Now all the body, arms and legs included, is covered with a very fine papular eruption. It first made its appearance as an urticaria, there being also a certain amount of eczema present. This lesion differs from the true prurigo of Hebra, in attacking the upper rather than the lower extremities. He believed, however, that it was closely allied to that disease. Sugar was found to be present in the urine. Internal treatment had been of no avail. Locally, a solution containing two drachms of carbolic acid to one ounce of glycerin and water had been applied, and the parts afterward dusted with powder.

DR. CAMPBELL then showed a case of

PIGMENTATION OF THE SKIN CAUSED BY THROMBOSIS OF THE VEINS OF THE LEGS.

J. O., 39 years old, German, and by occupation a sailor, seven years ago first noticed a red lump under the skin of the calf of the right leg; this ulcerated and left a scar. Since that time other small nodules have made their appearance always over the valves of the veins, but have not ulcerated; after their disappearance a yellowish-brown stain is left. When these lumps first make their

appearance they are very painful. The veins of both legs are slightly enlarged. Now both legs from the knee downward are covered with these pigmented patches, and new lumps are continually forming. The patient has never had syphilis or gonorrhœa.

DR. FOX then made some remarks on

BALSAM OF PERU COMBINED WITH VARIOUS METALLIC OXIDES AS AN ADHESIVE DRESSING FOR MANY LESIONS OF THE SKIN.

He said that he had lately been experimenting with certain applications for the purpose of obtaining a new form of adhesive dressing. The one that he had used chiefly was a preparation containing one part of precipitated oxide of zinc to three of balsam of Peru, which he had found the least stimulating of all the balsams. It formed a very soft ointment, was readily applied to the skin and easily hardened, thus completely protecting the parts. Ether and chloroform were added to some of the preparations, but they were too stimulating, as was balsam of fir, although Dr. Jackson informed him that in one case under his observation the latter balsam was milder. He (Dr. Fox) has applied this preparation over moist and exuding surfaces even in children without producing any more pain than an ordinary ointment. The objection to the use of an ointment was that it became dry, and was then friable. He had tried adding oil to the preparation, but found that it was too liquid. When the parts become dry and there is a tendency to fissuring, the surface could be made smoother and the cracks filled up by applications of oil. He had obtained the most gratifying results from the use of these preparations. The various metallic oxides, such as zinc, bismuth, magnesia, etc., could be employed in combination with the balsam of Peru. He had prescribed the balsam and oxide of zinc separately and had them mixed afterward. The effect of these preparations was to relieve the congestion of the skin, and it was accomplished more quickly than by the application of the ordinary oxide of zinc ointment.

In connection with this subject, DR. BRONSON showed a case of

ECZEMA BARBÆ.

A man, 25 years old, has an eruption covering the chin and upper and lower lips, also extending down on the neck. There is a slight amount of infiltration of the skin. A ten-per-cent solution of pyrogallie acid was used for a week without much benefit. Now, oxide of zinc one part and three parts of balsam of fir, with sufficient ether to make the preparation soft enough, was employed.

Dr. Bronson said, in reference to the preparation applied in the case just shown, that when the ether is added too quickly it separates, but that it can readily be mixed again. Where there are excoriated places the application of the preparation produces smarting, but he would not consider this a serious objection, as it did not inflame or congest the parts. Ether was less irritating than chloroform.

DR. MORROW said that there was, undoubtedly, a great future for fixed adhesive dressings in the treatment of many forms of skin affections. He thought that Dr. Fox's new preparations were commendable, but he failed to see their superiority over the gelatin and glycerin combinations. The latter were more or less elastic and were bland and more readily adherent. He used salicylic acid and alcohol to remove the scaling in psoriasis and then applied the medicated gelatin. He noticed in the case shown by Dr. Bronson that the dressing was cracked and fissured in many places, probably due to the extreme mobility of the

parts on which it was applied. He had never seen fissuring result from the use of gelatin preparations; the addition of ether caused irritation. He had of late used compound tincture of benzoin, from which the alcohol is evaporated, leaving a solid residue which is redissolved in collodion. This preparation was protective and healing. He had applied it every day for several weeks to a rodent ulcer involving the cheek and side of the nose, occupying a space about twice the size of a silver dollar. The surface was so sensitive that it bled very easily. He had used various preparations, but found that this was the best. It was applied by means of a camel's-hair brush, causing little irritation and forming a protective coating which was generally left in place from twenty-four to seventy-two hours.

DR. FOX said that he had used oxide of zinc and iodoform, in combination with balsam of Peru, in the treatment of ulcers occurring in dispensary practice. He had never been able to get a perfectly smooth and even surface with gelatin preparations.

DR. FOX showed two cases of

PSORIASIS TREATED WITH SALICYLIC ACID IN CASTOR OIL.

The first patient, a girl 8 years old, who has a psoriasis covering all the body. The patient's father and sister also have psoriasis. When she was admitted to the hospital, a two-per-cent solution of salicylic acid in castor oil was applied to the right arm, a weak solution being used because of the great congestion of the skin. The scaling is less, and many of the patches have disappeared, although the disease is extending in other directions. To the left arm the mixture of oxide of zinc and balsam of Peru has been applied, and there is even less congestion in this situation.

In the second case, the lower extremities are chiefly affected. This patient is peculiarly susceptible to action of ammoniated mercurial ointment, even a very small quantity exciting the severe dermatitis. Chrysarobin pigment has been applied to the right leg, and a five-per-cent solution of salicylic acid to the left leg, producing a marked improvement in the condition of the eruption in the latter situation.

DR. MORROW said that he had for a long time used a two to four-per-cent solution of salicylic acid in cosmoline in pityriasis, in scaly eczema, and for removing the scales of psoriasis, preliminary to a more active treatment. He was glad to know that castor oil proved so admirable a solvent. In many cases he believed that psoriasis would improve under an indifferent treatment. In some cases he had treated one side of the body with linseed oil, and the other with pyrogallie or chrysophanic acids, without any marked difference in the relative rate of improvement of either side. Of late, he had found that chrysarobin did not produce the irritative effects that he had formerly observed from its use.

DR. PIFFARD found that ten per cent of salicylic acid would not dissolve in oil, unless oil of lavender were used. He used oil of lavender and oil of eucalyptus, each half an ounce, and castor oil an ounce, as a solvent. Salicylic acid dissolved in liquor gutta perchæ possessed an advantage over a collodion solution, because in the former the salicylic acid rises to the top and can easily be shaken up, while in the latter it sinks to the bottom.

DR. FOX said that there was an advantage in using the preparation made with the oil, because it was not irritating. He was pleased to hear the suggestions made by Drs. Morrow and Piffard, and remarked that ordinary oils do not dissolve salicylic acid so readily as castor oil.

ADULTERATION OF DRUGS.

DR. PIFFARD asked the members present, what their recent experience had been in the use of white precipitate ointment. He was in the habit of using it, in its full strength, without producing dermatitis; but of late he had two cases where there was an intense inflammation set up.

DR. BRONSON said he recalled two cases in which pustulation was caused

by the application of an ointment containing fifteen grains of the white precipitate to the ounce.

DR. MORROW thought that we should always be on the look-out for incidental and unusual effects from drugs, whether using them locally or internally. He had seen dermatitis result from the use of almost every form of ointment. Oleate of bismuth or even oxide of zinc ointment sometimes produce irritant effects. This he thought depended less upon the impurity of the drug than the susceptibility of the patient's skin.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

(From our Special Correspondent.)

GENITAL DIABETIDES—CHROMIDROSIS—HERPETIC ANGINA AND ZONA OF THE PHARYNX—INFANTILE CRUSTS—ECZEMA—GENERALIZED EXFOLIATIVE DERMATITIS IN A SYPHILITIC—FRACTURES IN SYPHILITICS—PRECOCIOUS AND LATE OSSEOUS LESIONS IN HEREDITARY SYPHILIS—LESIONS OF THE LIVER IN LATE HEREDITARY SYPHILIS.

Genital Diabetides.—In causing to be published by our excellent colleague and friend Dr. Barthélemy his remarkable lectures upon Genital Diabetides, Prof. Fournier has popularized an eminently useful work, directing the particular attention of practitioners to the investigation of the primary cause of a cutaneous affection to which they attach too slight an importance; in addition he has presented the clearest, the most complete, and the most classic monograph in existence upon these accidents. Genital diabetides differ from other diabetides in that they depend upon two causes—the one, a general cause, which is the influence exerted by the glycemia upon the entire surface of the skin; the other a local, topical cause, which is the contact of the saccharine urine with the integuments of the genital organs. Saccharine urine rapidly undergoes an acetic or lactic fermentation which cannot be otherwise than very irritating, and it produces upon the cutaneous surface a parasitic cryptogamic vegetation discovered by Frederich, forming a slight, superficial, follicular, white coating upon the glando-preputial surface, or upon the internal surface of the labia minora, etc. . . . According to Balzer, it is histologically constituted by a mass quite similar to that of the *oidium albicans* and is composed: 1st, of spores isolated or grouped, rounded, oval, or elliptic, consisting of an envelope and a nucleus; 2d, of long tubular filaments, articulated, some ramified, others terminating in an enlarged extremity, some containing a variable number of spores, others empty and withered. The genital diabetides are always preceded by a genital pruritus more or less intense, but which sometimes assumes, especially in women, a violence altogether exceptional, and which may exist, at its debut, without the slightest apparent dermatosis, and even without the patient exhibiting any of the peculiar symptoms common to diabetes, polyphagia, polydipsia, polyuria, debility, hebetude, etc. It is, therefore, always necessary in the presence of a case of genital pruritus to examine the urine.

From an objective point of view the genital diabetides, in the case of women, present themselves under the form of a vulvar erythema, more or less general, then a vulvar eczema, sometimes taking on an acute form, with intense redness, tumefaction of the parts, serous exudation, general painfulness. Sometimes in the chronic form, with thickening and even hyperplastic tumefaction of the affected tissues: the labia majora are massive, swollen, but without true œdema: the labia minora are distended, elongated, and pendulous; the vaginal orifice and likewise the anterior portion of the vagina present an intense redness and pronounced tumescence of the mucous membrane, and here and there, *au niveau* the vulva and the vaginal orifice, are observed white follicular coatings which are due to the parasites. The principal characteristic of this diabetic eczema, is its obstinacy to local treatment, which only ameliorates the symptoms, its continual tendency to recurrences, and to fresh crops, as soon as the topical applications are neglected. Most often it disappears only with the glycosuria; still with much care and time, it may be subdued by employing temperate baths (of bran or starch) frequently repeated, lotions of the bicarbonate of soda or borax, vaginal injections containing thirty grams of boric acid to the pint, methodic sprinklings of powder in the cutaneous folds, etc.

In the male are also observed erythemas and eczemas; the most common form of genital diabetides consists of an erythematous balanitis, characterized by a simple intense redness of the glans. In a more advanced stage, there are found upon this reddened surface small excoriations, quite superficial, with a purplish, red base, rounded or irregularly oval in form, never preceded by vesicles; this is the balanitis herpetiformis. A third type is constituted by eczematous balanitis and balano-posthitis; most often it is a dry and desquamative eczema of the glans, which is of a color sometimes red, sometimes a dark-red, with an epithelium thick, cracked, broken, scaly, with here and there linear fissures, terminating in little furrows, some erosive, some bleeding, others covered with a crust. The same appearance is presented by the internal surface of the prepuce, which is slightly œdematous, and the extremity somewhat reddened. This balano-posthitis has an aspect and a localization so special that it should at once suggest diabetes. When neglected, it may gradually develop into diabetic phimosis by the progressive thickening of the prepuce, diminution and loss of elasticity of the organ, gradual narrowing, then complete atresia of the preputial orifice. Then the phimosis reacts unfavorably upon the balano-posthitis, of which it was the consequence, rendering it much more intense by causing prolonged contact of the urine with the diseased surfaces.

Dr. Martin has called attention to the incessant reproduction, in certain cases, of glandular vegetations in diabetics. In order to prevent these accidents, it is necessary, first of all, to treat the diabetes, then recommend the patient to always uncover the glans in urinating, and to wash, or at least carefully dry, the glans and prepuce after each micturition.

When genital diabetides are already developed in the male, they can be most successfully treated by the employment of the means before indicated for the same condition in women, viz., local and general baths, alkaline lotions, absorbent powders; it is quite possible to cure the phimosis without operation by frequently repeated injections of alkaline solutions, and, if there be acute inflammation with suppuration, a solution of nitrate of silver ($\frac{1}{100}$ to $\frac{1}{200}$). As soon as the glans can be uncovered, the contiguous surfaces should be isolated with an inert powder and dressings of lint. Prof. Fournier, in terminating his study of this subject, calls attention to the fact that there also exist gangrenous diabetides

of the genital organs : an accident exceedingly rare, but a case of which he had observed in his own practice.

Chromidrosis.—Since the last researches upon chromidrosis, to which I referred in one of my previous letters, the attention of clinicians has been directed to this particular point, and many cases of this curious affection have been published. At the meeting of the Paris Academy of Medicine, Dec. 2, 1884, M. Lison related the cases of three patients, all males, who were attacked with yellow chromidrosis of the neck. They presented no symptom of icterus, no coloration of the conjunctiva and skin, no characteristic reaction of the urine or other secretions, no morbid phenomena which would lead one to suspect an affection of the liver. The chromidrosis disappeared completely in these cases in the course of two or three months, without other treatment than occasional purgatives and alkaline drinks. The author declares that he was unable, notwithstanding the most careful investigation, to discover the nature and the cause of this singular infirmity.

Herpetic Angina and Zona of the Pharynx.—In an interesting communication made to the Congress of Blois, in 1884, Dr. Ollivier exposed his new researches upon the pathogeny of herpetic angina. From numerous cases cited by him it appears that herpetic angina may coincide with certain rheumatic manifestations and with a herpetic eruption characteristic of zona developed along the course of a nerve. The author has seen a herpetic eruption of the throat accompanied with a development of herpetic vesicles upon the internal surface of the cheeks and the lips, upon the anterior third of the tongue, the nasal fossæ, the conjunctivæ, upon the cutaneous surface of the forehead, the eyelids, the nose, and the lips—all regions innervated by the trifacial. The precise seat of the eruption, upon the territory of this nerve, and even upon the territory of certain branches of the fifth pair, the *ensemble* of morbid phenomena, the neuralgic pains, the swelling, the sensations of heat and burning, the cyclic evolution, seem to conclusively prove that there was in these cases a sort of storm in the sphere of the trifacial, and strongly point to the probability of the nervous origin of herpetic angina, which would then be a veritable zona. The author has even seen herpetic angina coincide with a zona of the suboccipital nerve. He does not hesitate then to affirm that certain herpetic anginas ought to be completely assimilated to ophthalmic zona and regarded as zonas of the pharynx. As to the etiology of these anginas, Dr. Ollivier believes with Drs. Verneuil and Leudet that they should be recognized as due, like other zonas, to multiple causes of diverse nature, but that for the most part they develop as the result of cold, especially when the patients are in a condition of systemic depression. It would be curious to ascertain whether these anginas ever recur, as it is well known that one of the distinctive characteristics of true zona is that it almost never recurs.

Infantile Crusts.—Dr. Descroizelles, physician to the *Hôpital des Enfants Malades à Paris*, has in one of his recent clinics studied this eruption. He shows that the *gourme* formerly served to designate almost all infantile eruptions, but at present it is restricted to those eruptions which have for their point of departure an eczema or an impetigo, and which are characterized at a period more or less advanced from their début by an abundant liquid exudation, then by crusts of variable thickness and aspect, accompanied by itching. These eruptions correspond well to the benign exudative scrofulides of Bazin in young children. After a study of cases of the cutaneous affections generative of crusts in infants, eczema and impetigo, the author remarks that these two dermatoses, after having passed through many phases, finish by forming quite extensive crusts, sometimes

whitish, or of a clear gray, nearly dry, and quite adherent, sometimes brownish, greenish or blackish, soaked with pus or blood, and easily detachable. The term *gourme* should be reserved for these concretions. The seat of predilection is the head, but it may also be found on other regions of the body. It is sometimes difficult to determine the cutaneous affection which originated them, whether an eczema or an impetigo, a matter of some importance from a prognostic point of view, impetigo being more rapid in its evolution than eczema, and also being inoculable. Impetigo gives rise to crusts softer, more yellowish, thicker, less adherent than those of eczema. To the eruptions which seem to partake at the same time of the characteristics of both eczema and impetigo, French authors have given the name of impetiginous eczemas. These are the cases which have led certain authors to regard them purely and simply as an impetiginous variety of eczema. This is an error of observation. One should not confound crusts with the parasitic affections of the hairy scalp, in particular with favus and trichophytosis, which may simulate them. It is also necessary in all doubtful cases to make a histological examination of the hairs and crusts.

That which is popularly called *la chapeau*, should not be confounded with these crusts, for it is only a simple product of the secretion of greasy matter, which is often found in the scalp of certain children, who have not been subjected to the proper use of soap. Thus understood, infantile crusts cannot have an unfavorable prognosis, they never leave cicatrices, but they may recur, or persist for a long time. They often have close connections with the lymphatic temperament, but they may also be observed in robust and well-developed children. The presence of certain parasites, especially pediculi, is quite often an active cause.

Contrary to the teachings of the Vienna school, M. Descroizelles does not treat as chimerical the fears of the older authorities who thought that a too rapid cure might coincide with grave visceral accidents. He thinks that we ought to carefully observe children in this regard, and always respect the dermatoses when we perceive that general disorders are produced as soon as the cutaneous secretions diminish.

If the eruption is very extensive it should be gradually cured, treating successively the various regions involved. The best methods of treatment consist in softening the crusts with olive oil or almond oil, then covering the diseased parts with impermeable dressings, such as caoutchouc or vulcanized cloth, and washing in water of walnut leaves two or three times a day. To facilitate this swaddling, bonnets, masks, gloves, stockings, etc., of rubber, are employed, as in eczema. When the crusts are removed, and the surfaces are not much inflamed, the cure may be hastened by applications of ointments of vaseline, medicated with either goudron, tannin, or calomel, ($\frac{2}{5}$, $\frac{1}{3}$ or $\frac{1}{10}$), according to the susceptibility of the patient. It may sometimes be necessary to have recourse to the oil of cade or to sulphur lotions. Where there is intense itching, emollients or feeble astringents may be employed, such as starch poultices, almond powder, subnitrate of bismuth, oxide of zinc, bran water, etc. Finally, M. Descroizelles regards it important to attend to the general condition of the patients, to give them iodide of iron, cod-liver oil, sulphurous and arsenical preparations.

We may remark, however, that the term, crusts, indicates only a particular aspect which eruptions of diverse nature may take on, and that in reality it does not respond to any well-defined malady, nor does it have, it seems to us, any scientific value.

Eczema.—I would call the attention of American dermatologists to an excellent

monograph upon eczema which has just been published by Dr. Deligny, Paris, 1885. They will find in it nothing peculiar to the author, but an excellent resumé and careful exposition of the ideas, the theories, and the therapeutic methods which are held in highest repute at the present time.

Generalized Exfoliative Dermatitis in a Syphilitic.—M. Poupon has just communicated to the Clinical Society of Paris the very interesting case of a woman 39 years of age who had syphilis in 1882, and who, in July, 1884, had a double iritis with synechiæ, and a perforation of the vault of the palate, for which she had been ordered mercurial pills, with two grams of iodide of potassium a day. The syphilitic accidents amended rapidly under the influence of the treatment, but, on the 15th of August, the patient observed upon her arms a redness, which rapidly extended to the trunk, and then became generalized over the entire surface of the body. The skin was red, tender, swollen, pruriginous. At the end of eight days the red eruption commenced to desquamate; this desquamation began on the arms and soon became generalized over the entire cutaneous surface. During the latter part of August, the entire month of September, and the earlier part of October, the redness and the lamellar desquamation continued in large imbricated scales upon the trunk, and in small scales upon the face. All the hairs of the head fell out in the early stage of the eruption, the greater part of the hair of the pubis, the axillæ, the eyelashes and the eyebrows likewise fell out. The nails were much altered. The patient, quite emaciated, had a succession of febrile attacks. It was impossible not to recognize this as a case of a disease examples of which are found scattered here and there in the publications of various authors, and which, three years ago, I described under the name of generalized exfoliative dermatitis, or malady of Erasmus Wilson. In America, England, and Germany, it has been confounded with a different affection termed pityriasis rubra. I may add that the patient entirely recovered.

Fractures in Syphilitics—Precocious and Late Osseous Lesions in Hereditary Syphilis.—Since the brilliant lectures of Prof. Fournier attracted the attention of French physicians to hereditary syphilis—a subject hitherto but little studied among us—publications bearing upon this subject abound in our country. In his excellent thesis upon “Fractures in Syphilitics” Dr. Gellé has remarked that we may observe in syphilitic children two classes of osseous lesions: epiphyseal detachments and fractures, either near the epiphyses, or in the middle of the diaphysis, lesions which give rise to pseudo-paralyses. Dr. Borne has taken up this question, and has recently given us a most conscientious and complete exposition of all the modern researches upon all the osseous lesions, early and late, of hereditary syphilis (Paris, 1884, 110 pp). I am obliged to refer your readers to this work, as it would require several pages to give even a resumé of the labors of Parrot, Lannelongue, Fournier, and of the author, which are here found condensed.

Lesions of the Liver in Late Hereditary Syphilis.—I will mention, in closing, the excellent memoir of my friend Dr. Barthélemy upon the lesions of the liver in late hereditary syphilis. He shows from 32 cases, many of which have not been published, that late hereditary syphilis determines four varieties of lesions of the liver: 1st. Lesions of an apparently purely congestive nature, characterized by a slight sensibility and augmentation of the volume of the liver—by a subicteric tint of the integument—by dyspeptic and rebellious gastro-intestinal disorders—accidents which rapidly disappear under the influence of iodide of potassium. 2d. More profound lesions determining a diffuse interstitial hepatitis—a cirrhosis rather hypertrophic than atrophic; this form of late hereditary syphilis

is frequent; in the earlier stages it may be cured by a methodic treatment, but neglected it kills the patient sooner or later. Sometimes the lesions present the mixed characters of sclerosis associated with gumma; it then constitutes the sclero-gummosus form, the course of which is quite variable in different cases. 3d. Lesions tending to the production of gumma in the hepatic tissues, gumma which in healing causes corrugated cicatrices so characteristically seen in the furrowing of the surface of certain livers. 4th. Finally, lesions exceedingly grave, accompanied by amyloid degeneration of the gland, the amyloid variety; another mixed form, the amylo-gummosus, is also sometimes observed. There is not, according to Dr. Barthélemy, any notable difference, from an anatomical point of view, between the hepatic lesions due to acquired syphilis and those due to hereditary syphilis: but the clinical picture is different in the sense that the infant or the young adult hereditarily infected, present the characteristic facies of the diathesis—characteristics so well studied by Prof. Fournier. It is necessary, then, in the presence of any affection of the liver of doubtful cause, of unusual course, or of singular development, to suspect late hereditary syphilis—since, next to alcoholism and malaria, it is the most prolific cause of hepatic lesions.

PARIS.

DR. L. BROcq.

Selections.

THE LOCAL ACTION OF MERCURY IN SYPHILIS.

It is generally admitted that mercury acts upon organs affected with specific lesions only through the medium of the blood, and hence, in the treatment of syphilis, our chief endeavor is to place the system at large under the influence of the remedy, local applications of the same being regarded merely as accessories. In opposition to this view, Professor Köbner, of Berlin, has published facts which go to prove the topical action of mercury upon syphilitic tissues, and has drawn therefrom some valuable therapeutical indications. Local treatment, he thinks, will often be successful in the removal of large scleroses—such as show themselves refractory to constitutional medication in all its forms. He lays special stress on the superior advantages to be gained in the treatment of indurated chancre by employing lotions and subcutaneous injections of formamide of mercury (1:100). The same measures are recommended for secondary and tertiary ulcers, and for flat condylomata. We have often been astonished at the rapid cures effected in cases of indurated chancre and condylomata by a combination of internal treatment with the local employment of calomel ointment 6-8 grs.: 30). We attribute them principally to a caustic operation resembling (though less in degree) that which nitrate of silver exerts with so much speed and certainty upon mucous patches. These last, we have also noticed, are quickly healed by the internal administration of mercurial salts. The endermic and hypodermic methods are likewise suitable for demonstrating the local efficacy of mercury, and some remarkable facts have been obtained through their employment. Thus Köbner has seen condylomata at the base of the mammæ dwindle and desiccate within six days after two sublimate injections made in their neighborhood, while other similar growths around the anus and in the pharynx remained unaltered. In one

case, where there was a papular syphilide on the shoulder, several injections at the centre of the eruption caused it to whiten rapidly, although another syphilide of the same size, which occupied the lumbar region, underwent no change. It has recently been shown by Zeissl that papulous ulcers, as well as indurated glandular swellings, are very refractory to subcutaneous injections of sublimate, but are readily absorbed *when the injections are made in their vicinity*. Again, in the employment of mercurial frictions, if these be carried out upon the feet of a patient affected with a general papular roseola, the eruption will disappear from the limbs eight or ten days before it leaves the body; and the same difference will be observed between the anterior and posterior surfaces of the latter, if the ointment be applied only on the back. On the other hand, it has been found that if, in syphilitic adenitis, the inflamed gland itself be subjected to this process, resolution will follow much sooner than if the constitutional effects of mercury be produced by either frictions or injections practised upon distant parts. Köbner emphasizes the utility of applying mercurial preparations to different regions of the body, as adjuvants to the internal treatment. It must be admitted, he observes, that all the lesions which survive this latter procedure—the induration, the cicatrices of primary sores, the engorged blood-vessels and glands—constitute so many sheltering-places in which the morbid germs can safely await their opportunities for further multiplication. We should, therefore, as speedily as possible, destroy all these lesions, as far as we have access to them, by the direct application of mercury. Thus the occipital, maxillary, and cervical glands, whose lymphatics are not included within the regions usually subjected to frictions and hypodermic injections, generally remain engorged; and this is often the case even with the inguinal glands after constitutional treatment. In cases of extra-genital infection, the glands corresponding to the inoculated locality are the most obstinately congested, and require the most persevering attention. Köbner has known large cervical swellings, following in the train of labial chancre, to disappear under the local use of a little gray ointment after constitutional treatment had been tried in vain. Nevertheless, even these measures will be unavailing when the swellings are partially due to scrofula, when their existence has antedated the syphilitic infection, or when they are kept up by persistent irritation of their lymphatics—in which last case it will be necessary to find out and remove the cause. Obstinate cervical engorgements are sometimes produced by ulceration of the nasal fossæ.

To sum up, then, the mercurial treatment of syphilis should be both local and constitutional. The former is sometimes sufficient by itself, or is the more rapidly efficacious; and, in every case, the remaining traces of the disease will call for local applications, repeated at proper intervals, until they are as far as possible removed.

Köbner has experimented with Oertel's mercurial soap, with oleate of the oxide of mercury, mercurial plaster, and local subcutaneous injections: they are all irritating to the skin, and are inferior in efficacy to freshly-prepared gray ointment.—L. BECO, *Ann. d. l. Soc. Medico-Chirurg. de Liege*, Jan., 1885.

CANCER IN SYPHILITIC SUBJECTS.

THIS question has been taken up by Dr. Ozenne, who deals with it exhaustively in a recent volume, referring especially to syphilitic cancer of the mouth. This latter is a hybrid disorder arising from the united action of syphilis and cancer. The former disease, when thus associated, is always tertiary, its prior stages having never been observed in direct connection with cancer. The combined lesions

of cancer and syphilis, when affecting the buccal cavity, are of several kinds, among which our author distinguishes three in particular—the cancrero-sclerous, the cancrero-gummatous, and the cancrero-sclero-gummatous varieties.

A. In the cancrero-sclerous form, the cancer under its usual aspect is sometimes the first to be manifested; sometimes, though more rarely, it is preceded by the syphilitic lesion; and, after a certain interval, we are confronted by a sort of mongrel condition, compounded of the products of incipient cancer, and the changes due to the sclerous glossitis. The appearance of the tongue is then as follows: The organ is enlarged, and displays the cancerous formation. If this be superficial, as a hard swelling, irregularly shaped, of variable size, and more or less prominent; if the epithelioma be interstitial, the tumor is sub-mucous, resistant, elastic, and seated upon an indurated base of undefined dimensions. In the neighborhood of the cancer are observed either the lesions of the superficial sclerous glossitis—smooth, shining, slightly-reddened indurations, circumscribed, or co-extensive with the mucous membrane—or, more frequently, all the evidences of a dermo-parenchymatous glossitis, whose hardness is diffuse and downward-reaching, so as to impart a peculiar sensation to the examining finger.

We cannot here delineate the affection in all its aspects. M. Ozenne places them under four classes, which he distinguishes according to the manner in which the hybrid structure is developed—*i. e.*, without ulceration; with a dermic sclerosis resembling psoriasis; with superficial ulcers of the mucous membrane, or with cancerous ulceration properly so-called.

B. In the second form—the cancrero-gummatous—the lesions are so closely united that the features peculiar to each of them are almost entirely effaced; we have an excavated ulcer with an indurated base like that of a cancer, but without the perpendicular walls or bleeding surface characteristic of the latter. Sometimes, also, other ulcers are found in the vicinity.

C. The third or cancrero-sclero-gummatous variety is the most complex; it combines the gumma, the cancer, and the dermo-parenchymatous sclerosis in very various proportions, sometimes manifesting one of these components quite distinctly, and sometimes blending them in utter confusion—thus presenting an exceedingly diversified appearance.

Such are the distinguishing marks of syphilitic cancer of the mouth—marks which are reproduced when the lesion is situated on the tonsil, the cheek, or the lips. As to its functional symptoms, these consist almost wholly in a diminution of the disturbances caused by either of the diatheses when alone present. Thus, hemorrhage is seldom met with, and pain, so frequent an accompaniment of uncomplicated cancer, is generally absent. Despite these advantages, the termination is no less fatal; since, as M. Verneuil has remarked, the prognosis depends upon that of the predominant neoplasm, and this, in the dual affection we are speaking of, is always cancerous. Treatment with iodine should always be resorted to when the existence of a syphilitic cancer is apprehended, as being undoubtedly applicable to the specific element in the disease, but should not be kept up too long, for fear of unfavorably affecting the cancer. The latter is sometimes amenable to surgery. But it must be borne in mind that mercury, so injurious in ordinary buccal cancer, is here also to be absolutely proscribed.

M. Ozenne concludes by citing several cases of syphilitic cancer affecting the nipple, the penis, the testicles, etc.—*Jour. de Méd. et de Chirurg.*, Sept., 1884.

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ALEPPO BUTTON.¹

BY

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NOT a great many articles upon the Aleppo button have been given to the profession. The studies of V. Carter, Lewis, Cunningham, Willemin, and others, it is true, have given us a fair view of the nature and the clinical history of this disease; nevertheless, the science of medicine has not yet been sufficiently enlightened upon this subject. Most writers have not had sufficient opportunities afforded them for continued personal observation, therefore it is not surprising that the exact character of the Aleppo button is as yet not fully understood.

During six years' residence in Aintab (on the border of Syria and Asia Minor) where the disease is endemic, I had ample opportunity for the study of this disease, having been myself affected.

Nomenclature.—Before proceeding with the general details of this disease, it may be desirable to note some points in regard to the nomenclature of the Aleppo button.

The word "Aleppo" attached to this affection would indicate that it is confined to Aleppo. Such is not the case, since it also prevails in Alexandretta, Antioch, Aintab, Oorfa, Malatia, Harpoot, Diarbekir, Mardeen, Bagdad, Bassonrah, and other Eastern places. In each locality

¹ Graduation Thesis, College of Physicians and Surgeons, New York, March, 1885.

different names are given to it. The Arabs term it "Habb-el-seneh" (one year button), and the Armenians "Daroo" (meaning almost the same thing). In Aintab they call it "Aie Bashi yarasu" (new moon-sore). Khourma yarasu (date sore) is another name, so termed on account of its prevailing in localities favorable to the cultivation of dates.

Some truth may be deduced from the names already given. I.—The sore lasts generally about one year. II.—Different changes are supposed to occur monthly. III.—It is endemic in many places where dates are cultivated. Still neither of these names carries with it any exact idea, and each has its objections.

Lewis and Cunningham have termed it the "Lupus Endemica," and Alibert "Pyrophlyctide Endemica," but these synonyms seem to be entirely out of the way. It resembles somewhat the lupus vulgaris, but nevertheless differs essentially from it; again the pathognomonic symptom of the so-called Aleppo button is not that of burning, nor is the tumor due to the accumulation of a serous fluid under the epidermis, as is the case generally with the pyro-phlyctides.

The word Oriental sore (T. Fox) seems to be better adapted, the only objection to it being that the sore does not prevail over all the Eastern regions. The Delhi sore and Biskra boil, so far as I can learn from authors and travellers, have the same pathological character as the Aleppo button; there may be slight differences, but these are probably due to climate, localities, and the general habits of the inhabitants. The Scinde boil, the sores of Roorkie, Moultan, Lahore, Meerut, and other crowded Indian cities; the boils of Aden, Crete, Yemen, and Cochin-China, says Dr. J. Fayrer, are varieties, if not identical.

However, as the word "Aleppo button" is that mostly used by the profession for the boil found in Syria and Mesopotamia, it will be well to keep it until further research discloses the exact causation and pathology of the disease.

Definition.—The Aleppo button is an endemic indurated and indolent cutaneous disease, without any constitutional symptoms, appearing singly or in number on the exposed parts of the body, as a rule in the form of a papule, which undergoes a series of changes, such as development and ulceration; cicatrizes slowly under the scab, and leaves a scar behind. It very rarely, if ever, attacks the same person more than once.

Etiology and Pathology.—Our knowledge of the etiology of the Aleppo button is at the present very imperfect. We know that it is irregularly distributed over a large area of the Oriental world. Its extension to any new locality by imported contagium is not traceable. When and how it originated in those places where the disease is indigenous is not known. Wherever it prevails, children are the chief victims; even among people not protected by a previous attack, less liability is observed

with advancing age. Infants under one year of age often escape, or if not, they have it in a slightly mitigated form. Sex has no direct predisposing influence; male and female are equally predisposed.

Strangers who have not had the disease before arriving in an area, at the favorable season, where the disease is endemic, are quite strongly predisposed to it, but this predisposition is by no means so strong as it is for the native inhabitants. Many strangers, having been exposed to it for a number of years, do not become affected, while the natives rarely, if ever, escape.

The liability to the Aleppo button, after one attack, usually disappears for the rest of life. Although Willemin mentions several cases who have had it a second time in a mild form and situated on the scar of the primary sore, I think that if a complete cure is accomplished in the primary sore, its occurrence a second time, if not doubtful, must be very rare.

If the disease is artificially produced, it seems not to have a preventive effect on the predisposition.

Various theories have been advanced by writers upon this subject with regard to the active cause of the disease.

Dr. Geber, of Vienna, has attempted by arguments (*Vierteljahresschrift für Derm. und Syph.*, Viertes Heft, 1874), drawn chiefly from the study of unfortunate cases, to prove that the so-called Aleppo button is nothing other than cases of lupus, rupia, scrofula, and syphiloderma; but the reasons for rejecting this explanation are overwhelming. I may only add that, if Dr. Geber had stayed longer in Aleppo, or if he had previously known that the natives generally do not take ordinary cases of Aleppo button to doctors for treatment; or if he had had occasion to visit native families and carefully examine the scabbed indolent buttons upon the face of children and the disfiguring scar left almost upon all the elderly persons, he should then have, probably, no doubt of the existence of such an endemic disease.

I myself have had a number of cases of syphiloderma, scrofula, etc., brought to me as cases of Aleppo button, after the required time had failed to accomplish the desired cure; certainly, such erroneous statements made by the patients are often misleading.

Dr. Renard has given the following theory: "The exaggerated sudoral secretion, which is the consequence of excessive heat during the summer, produces a morbid condition of the sudoriferous glands, as it is observed also in all glands when their work is excessive, etc." The objections to this theory are very strong; in the first place, the sudoriferous glands, as a rule, are not the seat of inflammation; second, the disease does not only attack those persons who are subjected to excessive sweating; third, it is found in many places where the temperature in summer does not

rise above 90–95 Fahr.; and lastly, were it a disease due to hyperidrosis and temperature alone, it should not be confined to certain parts of the Orient, as these conditions are present almost all over the world.

Seriziat, Alex, and others claim that this button should be compared to ecthyma and cachectic rupia which are the result of great debility of the system due to various causes, such as atmospheric and sanitary conditions. It is true that a warm and humid atmosphere, low and badly ventilated houses, accumulation of animal and vegetable putrefying matters, unwholesome and insufficient food, and neglect of the laws of health, are the great causes of human sufferings, but in this particular disease their importance seems to be secondary. Various facts prove that no amount of heat, filth, and bad food alone are sufficient to produce such an endemic disease. There are some places where a dry, mild, and healthy climate exists, yet all the inhabitants, poor and dirty as well as rich and clean, are predisposed to it, with only this difference, that when these conditions exist, they modify the duration and termination of the disease. Other things being equal, the disease terminates more favorably in those who are attentive to dietary and hygienic measures.

Sonrie thinks that the fine siliceous dust of the desert, carried away by winds, penetrates the pores of the skin; and that these particles, producing irritation, give rise to the formation of the buttons. But as there are certain localities which bear the same relation to the siliceous winds and remain unaffected, and as we have various places where the disease prevails and the access of these siliceous winds is inconceivable, we are justified in rejecting such a hypothesis.

The studies of Dr. Weber upon the boil of Biskra, which is considered almost identical with Aleppo button, have led him to believe that “Biskra boil is contagious and auto-inoculable.” If this statement is true about the Biskra boil, and is confirmed by other observers, then Aleppo button would, perhaps, differ greatly from that of Biskra button. I have seen mothers affected with the disease, who have not given the disease to their unprotected children, and *vice versa*. Not unfrequently, travellers, merchants, the students of Central Turkey College in Aintab, and others become affected with the button, go to and from their homes, and mingle with their friends without the slightest precaution, yet no single accident, so far as I know, has ever happened by the transported contagium of the disease. Being aware of these facts, I have no hesitation at all in saying that, if the Aleppo button is ever contagious, it must be in very rare cases. Neither is this button auto-inoculable, in the proper sense of the word. The number of the boils is the same from the beginning until the end of the disease; the excoriations and superficial ulcerations that are produced along the line of the discharging ichor from the primary boil must

not be considered auto-inoculations, because simple cleanliness of a few days will be enough to cure them, and they are always absent when proper cleanliness is observed.

Many writers and observers concur in the old prevailing opinion of the natives, which attributes the disease to the drinking water. It is true that the water of a good many places where the disease exists is very scanty and impure; on the other hand, the disease is also found in many other villages, towns, and cities that have an ample supply of pure, cold, soft water, free from any gaseous smell or contamination with refuse matter.

I am, unfortunately, unable now to give an elaborate statement with regard to the analysis of the water where the button of Aleppo is prevalent, but I will insert here the result of analysis of Oned-Kantara water, published by A. Laveran (*Annal. de Derm. et de Syph.*, Tome I., 1880, No. 2, Avril), where Biskra boil exists. The water in this place used for irrigation contains 2 parts of solids in 1,000, consisting of carb. lime and magnesia, sulph. lime and magn.; chlor. sodium and magnesium, and silicate sodæ. The water used for drinking and other domestic purposes contains only 0.794 solids per 1,000; the salts forming the solid being the same as in the former. From this analysis Laveran rejects the water hypothesis in Biskra button.

To the same conclusion we may reasonably arrive in the case of Aleppo button, and not merely from observing and analyzing the water, but principally from the following valuable clinical facts. 1. The disease, as a rule, makes its appearance in the autumnal months, so that, while strangers may remain with impunity the rest of the year, they may become victims in a few days or weeks in the autumn. 2. It occurs in infants three or four months old, who have not yet tasted the supposed vicious cup.

V. Carter has observed upon specimens sent to him by Weber from Biskra a parasitic organism characterized by a mycelium, with numerous orange-colored particles, pale, round or stellate granulation cells throughout the tissue of the tumor. A. Laveran in his article (*Annal. de Derm. et de Syph.*, Tome I., 1880, No. 2, Avril) about Biskra boil says: "Is it not strange that the organisms which existed in such a large number in the specimens sent to V. Carter were not observed by those who studied the Biskra boil? It has been impossible for us to find the parasite of V. Carter, although we have looked for it in Biskra upon a great number of individuals. MM. Kelsch and Kiener were not more successful than we were. It is probable that the organism observed by V. Carter was of an accidental production."

Specimens of three or four months old buttons, which I had brought

from Aintab, preserved in alcohol, were kindly examined by Dr. G. R. Elliott, but did not show any such organisms as described by V. Carter.

Although the characteristic cryptogams of V. Carter in Biskra boil may have been accidental, since many other observers were unable to find them; and although no such organisms could be found in the specimens of Aleppo button, still the parasitic origin of this endemic disease, after all, is not improbable. We have seen that all the other theories advanced as explanations of its etiology have been unsatisfactory. The clinical history as well as the pathology of the disease indicate that there exists some special cause, and all the others mentioned must be considered as adjuvants. What this special active agent is that produces the disease has not yet been discovered.

As the disease generally appears like mosquito bites in the autumn, it has led the people of some places to believe that the button originates from the bite of certain insects, but no actual demonstration has yet been made to prove this theory.

As a matter of curiosity, I here will mention an accident which happened to one of our family during our residence at Aintab.

Hetoom S., aged 16, had been in Aintab two years and had not yet been affected with the endemic button. One evening in the autumn of 1880, he went to bed at about 9 p.m.; before he fell into sleep, he cried out that something had stung him quite severely. He and those who were around and about him searched for the insect or whatever it might be, but nothing could be found, excepting a small papule upon the posterior aspect of the calf where he had referred the bite. This red papule eventually developed into a regular Aleppo button.

This sting may have been an actual occurrence, or it may have been only a sensation caused by the button already begun.

Those who have travelled during the summer or first autumnal months through Arabia and Mesopotamia, where this disease prevails, undoubtedly remember how the incessant and intolerable annoyance of mosquitoes and other insects intensify the suffering from the scorching sun. In these regions there are found varieties of insects that produce, by a single bite or sting, large indurated lumps which may last for several weeks, and sometimes are followed by ulceration.

Is it not probable that this endemic disease is produced by the bite or sting of some special insect peculiar to certain soils and climate?

The close connection between the time in which this button develops with the time when most insects arrive at maturity; the endemic and non-transportable character of the disease; the origin in the superficial layer and exposed parts of the skin, and the limited geographical distribution of the disease are arguments in favor of this hypothesis.

Microscopical examinations so far made on the Aleppo button, show

that the composing elements of the tumor are, principally, neoplastic cells of the surrounding normal tissue and apparently produced by a process of cell proliferation. It is possible that this excessive cell production is due to the peculiar irritating character of the poison of the insect, which may have injected it; the ulceration which follows the tumefaction is due to disintegration and death of these proliferated cell elements.

Anatomical Characters.—For the anatomical character of the Aleppo button I am indebted to Dr. G. R. Eliott of this city, who, having made repeated sections of the specimens I had given him, furnishes the following report:

“This disease appears confined to the epidermis and corium, extending through the latter quite to the subcutaneous tissue. The area of disease seems composed almost entirely of small round inflammatory or formative cells and epithelial elements. The line of separation between the diseased portion and the surrounding tissue is distinct, there being no gradation between the healthy and diseased tissue. The hair follicles appear intact, and there is no evidence of the disease beginning in the glandular structures. No cryptogams or other micro-organisms are present in sections examined.”

Clinical History.—The development of this disease begins, independently of hair follicles, as a small papule, bearing all the characteristic features of a mosquito bite or acne, and is about three or four mm. in diameter. Its color, which is pinkish, disappears on pressure. The progress of this papular stage remain stationary for some time, as if it were undergoing a period of incubation. After this indolent state has persisted for several weeks, it becomes active; its vascularity as well as its size and tumefaction increase slowly, and its base grows deeper, harder, and larger, and becomes adherent to the surrounding tissues, as is the case with the malignant tumors.

To the touch it is boggy; in appearance it is smooth and glossy; but as the tumor progresses and new elements are deposited in its interstices, it acquires a dark livid coloration, probably due to venous congestion. There is no pain and no general symptoms. Slight sensitiveness exists, and a burning sensation may be felt, but it is of short duration. Itching, which is present in many cases, is sometimes severe, so much so that the continued scratching produces serous oozing; this itching is not so peculiar in adults as it is with children.

As all these changes occur, the centre of the neoplasm softens, and from this degeneration a slight amount of purulent and often bloody fluid accumulates, but not sufficient to cause bulging; later, this small central soft tumor bursts, and gives out a few drops of matter, which, adhering to the orifice, forms a scab of brownish-gray color. This scab is gradually enlarged and thickened by the addition of fresh exudation,

which proceeds from continued ulceration until it nearly covers the whole surface of the induration.

This scab is permanent, and more or less conical, bearing some resemblance to an oyster shell. If the scab is removed, the surface of the sore presents a shallow ulcer, with fungoid or spongy bottom; its margin, more or less ragged, is irregularly oval or circular in shape, and, if left alone, in a few days a new scab is formed. If the scab is undisturbed, it remains, and the discharge of ichor from its margin continues for months, until the entire indurated lump gradually disappears by suppuration and absorption, when discharge ceases. Then the process of cicatrization sets in from the centre of the ulcer beneath the scab, at which time, the latter falling off, some narrow crescentic indurated and encrusted pieces remain around the scar. These pieces are also absorbed



in a few weeks, then the entire cicatricial surface, which was at first tender, of pale-red color, and covered with a thin film, gradually disappears and assumes the appearance of the normal skin, leaving a permanent and disfiguring cicatricial scar.

The size of a well-developed button varies greatly; it may be from one-fourth to two inches in diameter, but the usual size is about one inch; it rarely exceeds two inches. When large, they are, as rule, few in number; when numerous, they are of the minimum size.

The duration, roughly speaking, is about one year; but there are cases that get well in a much shorter period, while others become chronic and last for a number of years. When the size of the button is not very large, and the constitutional condition of the patient is favorable, the duration is generally not more than five to seven months; on the other hand, when the button is large and the system is under the influence of some general vice, the duration is longer.

Complications and Sequelæ.—There is no particular disease that is apt to be complicated with the Aleppo button, though, of course, enlarged glands, with or without suppuration in the neck or elsewhere, and various acute or chronic, local or general affections may coexist accidentally. Libert and others speak of phlebitis, metastatic abscesses, and erysipelas as occasional complications of this disease. Although these may coexist with the button, my experience would not lead me to speak of them as complications; on the contrary, erysipelas, which is common in the East, rarely affects those children who are subjects of this disease.

Much deformity often results either from the contraction of the scar which it leaves or from the destruction of superficial tissues; for example, ectropion of upper or lower lids, distortion of the mouth, stricture of nares, and entire loss of alæ or tip of the nose. The size of the scar is in direct proportion to the ulcerating surface. Its depth and color are quite similar to the scar from a burn. Hair grows fairly well on the scar, provided that the tissues are not much destroyed by escharotics and other severe measures.

Diagnosis.—The differential diagnosis of the Aleppo button is generally so easy that it ought not to be mistaken for other skin affections. In the first place, it is well to ascertain whether or not the individual is a native; if he has ever visited places where the disease is endemic; whether he has been affected before. It is also desirable for us to know at what time of the year the button made its appearance. In forty-eight out of my fifty recorded cases, the beginning or papular state was first noticed in autumn, the remaining two cases beginning apparently in the spring. During the winter, the forty-eight cases presented an indurated tumor, and in the following spring the most prevalent feature was that of suppuration. During the summer, cicatrization generally occurs, though about five per cent become chronic.

After the preliminary history has been taken, a careful examination of the affected surface will enable us to distinguish it from a mosquito or flea bite, and from acne, both of which closely resemble it during the first few weeks. The eruptions caused by these insects are temporary, usually disappearing in a few days. If it is acne, the papule soon fills with a sebaceous fluid or its characteristic comedo, while the Aleppo button has none of these characteristics, and grows slowly.

The button, as a rule, attacks the exposed parts of the body. Its usual seat is on the cheeks, tip and sides of the nose, eyelids, angle of the eye and mouth, ears, or forehead. Frequently it is found on the wrist, hand, foot, forearm, leg, and knee; it never occurs on the palmar, plantar, or mucous surfaces. Its occurrence on the trunk, upper part of the thigh and arm seems to me rather doubtful, although M. Libert in his thesis says: "I was affected on the thigh, axilla, and trunk." He

further adds: "The boil situated in the axilla burrowed under the skin, and produced slight phlebitis, afterward breaking out on the thoracic region on a level with the third rib." I am at a loss to understand this history, having seen nothing like it during my six years' residence in the Aleppo region. So far as my knowledge goes, the button remains always in its original focus, never assumes a serpiginous character, and never travels through the neighboring tissues to burst out at a distance.

Papular and ulcerating syphilides may be confounded with this endemic button in its corresponding stages; but an inspection of the pharynx, mouth, and other portions of the body, as well as the history, will afford us sufficient evidence regarding the character of the disease. I must further add that the number of buttons is generally limited to from one to five, seldom more, though exceptionally there may be as many as twenty. The greater chronicity, comparatively slow growth, the resistance to specific treatment, as well as the limited number and special situation of this button will certainly lead us to a correct diagnosis.

Lupus vulgaris is most likely to be confounded with this disease, inasmuch as its special preference for location, like the Aleppo button, is the skin of the exposed parts, and especially of the face.

The indurated base, greater protuberance above the level of the skin, the thick, conical, brownish-gray scab, and the limited duration without medical treatment, are the characteristics of the Aleppo button. A patch of lupus is usually formed by the coalescing of numerous aggregated reddish-yellow or reddish-brown blotches, while Aleppo button ulcer develops by a single red papule, or, if there be more than one, they rarely coalesce.

Lupus is quite a destructive disease, and it may attack the deeper tissues, while this button almost never extends beyond the deep layer of the superficial fascia; finally the button, unlike lupus, never changes in its original focus, the primary papule is always the centre of the growth, and it also never presents in a given patch various stages, such as small papules in one spot, ulceration on the other, and cicatrization on the third, as is commonly the case with lupus.

Scrofuloderma, ecthyma, pemphigus, and other skin diseases are so distinct that it is hardly necessary to mention the differential points.

Prognosis.—This disease, so far as I know, has never proved fatal, though death has in some cases occurred from poisoning by the use of improper remedies. Its tendency is toward recovery within a year in the majority of cases, but there are a number of cases which become chronic and last for many years. Ten of my fifty recorded cases had existed more than a year; some three, some four, and one seven years. Besides these ten, I know of two other cases, one of which had continued about ten years, and the other twenty. In the latter case, the button

had changed its original character, becoming epitheliomatous, and recovery ensued after complete removal. There was no doubt that this epitheliomatous ulcer was the continuation of the original Aleppo button which had existed since childhood.

When the disease becomes chronic, it resembles lupus so closely that it would perhaps not be improper to say that the Aleppo button in some cases terminates in lupus, the principal distinction being that the button is stationary and never becomes so destructive a disease.

Is the Aleppo button inoculable?—According to Russel, the dog, the cat, birds, and almost all animals may be affected. Lundtz admits occurrence only amongst dogs and cats. Willemin has observed it in two dogs only.

Desgenettes has made several trials of inoculation without conclusive results.

Willemin has inoculated sixteen individuals in Aleppo, with the lymph secreted by the human Aleppo button. The inoculated persons were six children of Aleppo, nine adult strangers, and one native of eighteen years, who had already been affected in his childhood. Upon the foreigners, eight were refractory, but with the ninth, as well as with the young native of eighteen years, and also in two children, the inoculation succeeded.

In Aintab, I tried inoculation upon four medical students who had not yet been affected with the disease, nor had they lived in localities where the button prevails. In one of these cases I used the purulent discharge alone, which gave a negative result. In the other three, I used both the discharge and scab derived from one child, and with success. Several days after the inoculations, ulcers began to develop until they reached about one-half to three-fourths of an inch in diameter, and although these ulcers bore some characteristics of the ordinary button, they nevertheless differed essentially in many points. They were more superficial, more inflamed, discharged more freely, and ran an acute course, terminating by cicatrization after several weeks. One of these three cases, upon whom inoculation had shown the best result, was affected by a normal button a year after the inoculation.

It seems to be difficult to arrive at conclusions from a few experiments, but the single case of mine and many other cases that have been experimented upon by others, indicate plainly that, although inoculation of the button may produce certain ulcers which bear some characteristics of the Aleppo boil in an acute form, these artificial ulcers do not give immunity from a second attack, as is the case after a normal attack.

The presence of the Aleppo button in horses, cats, and birds around the Aintab and Aleppo region is quite doubtful. It is possible that

dogs may have it, as it has been noticed twice by Willemin. I saw accidentally one hound which had quite a number of nodules upon its nose, and I suspected it to be Aleppo button, but could not be sure about it.

Treatment.—The treatment of the Aleppo button is both hygienic and medicinal.

Hygienic measures, as in general therapeutics, are in this particular disease indispensable, although I must confess that sanitary measures are not altogether preventive. Still there is no doubt that they modify the severity as well as the duration of the disease. The great proportion of the cases that become chronic, are dirty, scrofulous, rachitic, and badly nourished subjects. The influence of hygiene is more pronounced among the foreigners than among the natives. I have noticed that most strangers who live in good sanitary conditions have escaped the disease even when living in the region for ten or more years.

As the disease generally originates in the autumn, special care must be taken in this season. It is not customary in these regions to sleep upon bedsteads. Most natives, as a rule, place their bedding directly upon the ground in the yards or upon the roof of the houses, on account of the troublesome heat in the buildings. Such a way of living seems to be very favorable for the development of the button. The less liability of the disease during the early infantile age among the natives is due, I think, to the care which is taken at this age. The careful mother bandages her babe like a mummy from head to foot and lays it in the cradle. A careless mother often omits this custom for her convenience and takes it in her bed without the usual swaddling. It was mostly in this latter class that I found the Aleppo button under the age of one year.

Therefore, to the sanitary measures, the use of bedsteads and mosquito-nets would be valuable additions.

Various medicines, both locally and general, have been used by natives and other observers, but no drug has yet been found to have a direct effect upon the disease. It is an extremely intractable disease, and although it has all the feature of a local disease, nevertheless it is not purely so; there is no doubt that the entire system, sooner or later, comes under the influence of its specific ferment as a strong immunity from a second attack is produced.

Internal medication is useful in many cases, especially in those where more or less tendency to chronicity exists. Chalybeates and iodides are the most efficacious drugs, especially for children and when combined; in some cases, the addition of cod-liver oil is very useful, particularly if the subject is of strumous or rachitic diathesis. Arsenic and other alteratives are not of great value.

Locally, different medicines must be used in its different conditions. In the earliest stage of the disease, when it is a papule of a few lines in

diameter, destruction with various caustics and escharotics proves to be useful in some few cases. It must always be borne in mind that unless the destruction is thorough, the button will certainly again appear.

In the early stage of the disease, I have tried abscission in several cases with good results, but it is yet a matter of uncertainty whether the button will redevelop after excision.

When the base of the button has penetrated the deep cellular tissue (subcutaneous), abortive measures cannot be used without producing a large scar.

Various pastes made of arsenic, corrosive sublimate, sulphate of copper, and other escharotic agents are used by native physicians and barbers. They make a few applications at the time of ulceration which is followed by inflammation, sloughing, and later by cicatrization.

Any stimulating application during the stage of suppuration will encourage the absorption and consequently hasten the cicatrization, but all these measures, as a rule, are apt to leave a deeper scar; therefore, the less the scab is disturbed the smaller the scar will be.

The best local medicine we have at present is tincture of iodine, which can be applied from the beginning until the end of the button. It is better to apply it all over the tumor, once or twice daily. Its checks its enlargement and shortens the duration.

CASE OF EPITHELIOMA OF THE PENIS; OPERATION.

BY

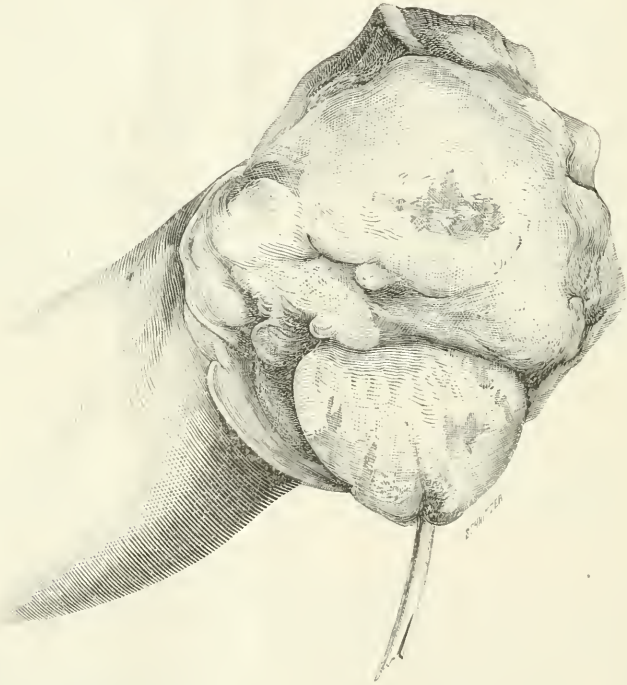
WILLIAM H. VAN WYCK, M.D.

Surgeon to Charity Hospital.

G. M., æt. 63, native of England; laborer; widower, was admitted to Charity Hospital December 29, 1884. There is nothing in his family history which presupposes heredity, as his parents died of old age; mother at 82 years, father 85 years. He has two brothers living, aged respectively 64 and 66 years, both in good health. Patient has always enjoyed good health; never seriously ill, except from an attack of scarlatina when a child. Had gonorrhœa once when a young man. His present trouble commenced in July last, when he noticed a small spot of incrustation on the anterior and upper part of prepuce which caused him slight pain at times, but none on pressure. From that time on, its progress was quite rapid, ulcerating through the prepuce and involving the glans penis. Pain continued slight up to October, when there was a

moderate hemorrhage. The pain now became much more severe, and as he describes it, "like a darting shot through the penis."

At the time of his admission to the hospital, the patient was very much debilitated and emaciated, probably the result of neglect and poverty as much as disease, since all the organs of the body on physical examination were found normal, with the exception of the penis, the anterior half of which was increased in circumference; the posterior half normal; the skin relaxed and of a dusky bluish color; glands in left inguinal region not much enlarged, but forming a chain-like elevation in



groin. The glans penis, which is entirely enveloped by the new growth, is as large as a moderate-sized orange, and is nearly at a right angle to the axis of the penis. The neoplasm is made up of large masses separated from each other by deep fissures which are circular and ulcerated, the base being moist and of a gray color. The granulations are flabby and broken down in spots. There is a slight serous-like discharge which is of a putrefactive odor. The masses themselves on the anterior surface, forming part of an arc of a circle, are grayish-white in color, studded by numerous pin-head bloody points. From the apex of one of these grayish-white masses in the anterior surface and to the right, the patient urinates without

any difficulty or pain, passing a stream of nearly normal size. The posterior or under surface is made up of numerous superficial ulcerations with indurated edges and base. It was deemed advisable by my colleague, Dr. R. W. Taylor, who was visiting the service at the time of the patient's admission, to endeavor to improve his condition by extra diet with stimulants and tonics, combined with topical applications before operating. He was ordered to bed, and penis dressed with a solution of the bichloride of mercury, 1: 4,000. Internally tonics, extra diet, and $\frac{1}{2}$ iv. spts. frumenti daily. Under this treatment the patient steadily but slowly improved both physically and mentally, and on March 14 the penis



was amputated about midway between the glans and the pubis. As a preliminary step of the operation, and at Dr. Taylor's suggestion, the penis was transfixed with two long bonnet pins passing through the corpora cavernosa X-like, immediately in front of the point selected for incision, and avoiding the corpus spongiosum. These pins served a double purpose, that of a guide against which the operator's knife could rest and follow, and also as a means of extending and steadying the penis. The corpora cavernosa were cut through, and the corpus spongiosum dissected out, and cut through one-half inch beyond the stump. The urethra was slit back on either side to the stump, the upper half retracting, and the under part reflected back and stitched to the integuments

with six fine silk sutures. The catheter was used for a few days after the operation, and then discontinued, as urine was voided without pain or difficulty.

Simple cold water dressings were applied to the cut surfaces, which healed entirely in about five weeks, leaving an excellent stump with a meatus flush to it. The new meatus admits a No. 23 French sound. In this case, while the prepuce had always covered the glans, there was never any tendency to phimosis, until after the ulceration was well advanced; so phimosis could hardly be regarded as the exciting cause of the disease in this case. In almost all cases reported, there is one or the other, of the half dozen or more causes mentioned in works on surgery, appropriated as *the one*. The etiology, I think, is generally accepted as due to constant and prolonged irritation, no matter what the cause of irritation may be. Demarquay, in his monograph, "*Maladies Chirurgicales du Penis*," Paris, 1877, page 356, thus differentiates true cancer and epithelioma of the penis in the following concise summary. "To sum up, the microscope has demonstrated that cancer of the penis is sometimes true cancer, and sometimes cancroide or epithelioma. Clinical observation shows that these two forms have a very different course, and that their prognosis is far from the same; in truth, in the great majority of cases, if not in all, cancer returns invariably: sometimes in the part originally affected, and sometimes and more frequently in the parts to which the lymphatics of the affected region spread, and finally, in a certain number of cases, the cancer appears in a distant organ. Cancroide or epithelioma is, on the contrary, a local affection which is limited to implication of the neighboring ganglia, is not complicated by visceral lesions, and is susceptible of radical cure by operation." These two forms are, therefore, clinically and pathologically distinct. Out of 134 analyzed observations, I have found 22 cancers and 112 epitheliomas—a percentage of 1 to 5.09. Thus the frequency of true cancer of the penis is much less than stated by Lebert in his "*Traité des Maladies Cancereuses*;" for this learned pathologist says that scarcely one-third of the affections which he had examined were of a cancerous nature, and that two-thirds were epithelioma.

VENEREAL NOTES.

BY

A. H. OHMANN-DUMESNIL, A.M., M.D.,

St. Louis.

Peri-urethral Abscess.

DR. JNO. WARREN makes the following assertion on page 142 of the JOURNAL for May, 1885. "By some the seat of these abscesses are considered to be in the lacunæ, which rupture externally, leaving a fistulous opening; or they may break into the urethra, but others think these abscesses begin in the connective tissue surrounding the urethra, as they do not impede the passage of urine." About a year ago, I observed a case in which it was clearly demonstrated that the latter may take place. A gentleman called to obtain advice for a case of gonorrhœa in which the discharge was very abundant. Upon examination, I noted that there was present near the peno-scrotal junction a peri-urethral abscess of the size of a large filbert. It was promptly opened and the pus evacuated. It was entirely confined to the connective tissue, and healed kindly and rapidly. There never was the least sign of any fistulous opening into the urethra, and it is most probable that in many of the cases observed, where such fistulæ were found, the pus had burrowed its way, and produced a condition which would never have existed had the abscess been opened early enough.

Syphilitic Tubercles of Meatus and Urethra.

L. Beco (*Annales de la Société Médico-Chirurgicale de Liège*, Jan., 1885) has called attention to the beneficial effects of mercury applied locally. Lately a case came into my hands which illustrated this in a marked manner. A young man suffering from syphilis had been under treatment for a considerable length of time, and still a number of local lesions persisted. Those which proved the most troublesome were tubercles about the meatus, and extending into the urethra about one-quarter inch. They suppurated after some time, and the opposed surfaces had a tendency to adhere, so that whenever the patient wished to pass water, he took a pen-knife and made an opening for the urine to pass. Tubercles existed on the forehead and other places, and were a source of annoyance also. Continuing the general treatment which he had been following, I advised him to make local applications of a ten-per-cent preparation of oleate of mercury. It is probable that he was given a stronger preparation, as he complained of the extreme pain it caused.

However, the daily application of this quickly brought about a change of condition. In less than ten days, the local syphilides had completely disappeared and his skin was clean. In the same case, the induration of the primary sore still remained after an interval of six months, involving a large part of the prepuce, and of considerable hardness and thickness. This also disappeared under the influence of the local treatment.

Case of Persistent Chordee.

I have denominated this persistent chordee from the fact that no treatment apparently had any effect. The subject was a young man of fine build and appearance; who had contracted his first gonorrhœa. He indulged in alcoholics, and chordee suddenly made its appearance one night. He consulted me, and I ordered bromide of potassium internally, and injections of chloral every evening. He did not see me again for several days, when he told me that the trouble had disappeared, but not through the effects of the medicine. For two or three evenings, he had taken three hundred grains of the bromide each evening in the space of about an hour, and had injected the urethra several times with a solution of chloral hydrate. Despite this, as soon as he fell asleep, the painful erection would take place and put him in agonizing torture. The exudation into the spongy tissue was confined to one side, but was extensive and had been very rapid. It subsided in a few days, and the gonorrhœa disappeared in a short time. The anaphrodisiac effects attributed to bromide of potassium did not seem to be demonstrated in this case.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

154TH REGULAR MEETING, APRIL 28, 1885.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. PIFFARD exhibited two dogs which were subjects of

MANGE.

The first one shown was a Gordon setter, which had suffered from trichophytosis two years previously. In this case the patch had been attacked with the utmost vigor, resulting in the cure of the disease, but leaving a spot permanently bald.

The second dog was a Yorkshire terrier that had been brought to him about a week before. In this case the hair had fallen from the greater part of the dog's body during a period of about two months, and the fall was unaccompanied by

any signs of local irritation, the skin not being in the least congested or presenting any abnormal appearance whatever except the loss of the hair. With reference to these cases, Dr. P. remarked that the common word mange was applied to numerous cutaneous affections of the canine family. He said that for many years he had kept dogs, and that several of his dogs had suffered from "mange." Besides this he had examined a good many dogs belonging to friends, and had observed several distinct forms of cutaneous diseases among them. One form, which was by no means common, was clearly an eczema, and was, perhaps, due to overfeeding, lack of exercise, etc. This form was, of course, not contagious. The other forms of "mange" were contagious, and referable to parasites. Dogs suffered from the invasion of itch insects (*Sarcoptes canis*), from lice and from an entozoon folliculorum. Dr. P. had never personally met with any of these, but stated that the follicular parasite sometimes gave rise to exceedingly grave symptoms. Of the phyto-parasitic diseases, ringworm was not infrequently met with, but the most common form of mange that he had met with was not due to any of the causes mentioned. It was characterized by pityriasis, accompanied with pruritus, and in a short time by falling of the hair. The patches were usually circular, which united by extension. The pruritus was quite severe, and led to scratching, with the development of various secondary lesions. This form of disease Dr. P. believed to be due to a phyto-parasite, but he had not given the matter thorough examination. It was a readily curable affection, as almost any of the mange cures in common use would cure it. These were almost without exception composed of the following ingredients: Tar, turpentine and sulphur, with a little oil. Crude petroleum, kerosene, and other substances were sometimes used. In the forms of mange due to animal parasites, the combination above mentioned was very effective. Dr. P. was by no means certain that the last described form of mange was confined to dogs, but suspected that it might be the cause of some of the cases of alopecia furfuracea met with in men. In the human subject the affection was almost always chronic, while in the dog it was an acute affection. There was still another form of mange, exemplified in the Yorkshire terrier shown, the nature of which was not clear.

Dr. Fox, for Dr. F. TILDEN BROWN, showed a case of

PSORIASIS OF THE PENIS.

The patient, a man 29 years old, has had psoriasis ever since he was ten years old. Four years ago he contracted syphilis, and was treated for three years with mercury and iodide of potassium. About four months ago, an eruption appeared in the mouth, on the mucous membrane of the nose, and lower lip. This was seen by Dr. Keyes, who said that it was not syphilis. A few weeks ago a scaly eruption made its appearance on the glans penis. He also has characteristic patches of psoriasis scattered over the body, and elsewhere. On the inner surface of the lower lip, on the hard palate, and on the left pillar of the fauces are white pearly patches.

If this eruption were seen on the penis and nowhere else, it might be mistaken for a lupus erythematosus, and if taken in connection with the lesion in the mouth, without looking elsewhere, syphilis would, no doubt, be suspected.

Dr. BRONSON presented a case of

UNIVERSAL ECZEMA FOLLOWED BY PIGMENTATION.

The patient, a wood-carver, 29 years old, has for the past seven or eight months had eczema, in patches varying in size from one to three inches, occupy-

ing mainly the upper and lower extremities, and also scattered over the body. The peculiar features of the case are the great amount of infiltration present, and the pigmentation of the parts affected. The eruption itches greatly, and there are marks of scratching. On the right side of the tongue are the remains of what appears to have been a syphilide. The epitrochlear glands are slightly enlarged.

The case was shown as an illustration of that class of cases referred to by Dr. Fox at the last meeting, when speaking of eczema modified by syphilis. The lesion was regarded as eczema, but the question was raised whether it might not be an eczematous transformation of a pre-existing syphilide.

DR. PIFFARD showed a case of

SYPHILIS.

The patient had a chancre four years ago, followed by an eruption. He has had the present lesion for about nine months. The left nipple and breast are covered with a scaly and tubercular eruption, the space occupied being about four inches. There is another and smaller patch on the left side of back, beneath the inferior angle of the scapula. The left forefinger, the ball of the thumb, and the soles of both feet are also covered with a scaly and tubercular eruption. One peculiar feature of the case is the occurrence of the eruption on the nipples, and it also presents many points of resemblance to an eczema.

THE NATURE AND TREATMENT OF ALOPECIA PRÆMATURA.

In opening the discussion, DR. PIFFARD said that there were a few propositions which he would mention, and which he believed would be undisputed.

There is a very large proportion of cases of alopecia præmatura preceded by pityriasis, and it was to this form he wished to direct the attention of the members this evening. Pincus was the first one who called attention to the essential connection between pityriasis and alopecia præmatura. He called the disease alopecia furfuracea. Malassez and Chincholle pointed out that in the scales a definite fungus was found in all the cases that they examined microscopically. Dr. Piffard had verified these observations. At that time, Dr. P. did not consider pityriasis to be due essentially to a fungus, and regarded the lesion as a constitutional, rather than a local one. More recently Lassar and Bishop demonstrated that alopecia præmatura could be transferred from man to brute, by taking the scales and hairs from a man, mixing them with vaseline, and rubbing the mixture into a rabbit's skin, and producing a similar lesion. Three or four years ago, Dr. P. had a dog who had mange, and by observing the lesion in that animal, he was satisfied that it was parasitic, due to a vegetable parasite, but not a trichophytosis. In the dog it commenced as a pityriasis, there was considerable irritation, and the animal almost tore itself to pieces, and a considerable amount of hair fell off. The condition was so bad that he thought of shooting the dog. He finally went to a dog doctor who gave him a mixture containing sulphur, tar, and turpentine. In less than a week the dog ceased scratching, and in six weeks the hair was growing.

Unna stated some time ago that he had found sulphur, locally applied, to be of service in alopecia, and had been led to employ it from seeing a veterinarian use it in mange. Dr. P. thought that the mixture above mentioned might be of service to the human pityriasis and alopecia, and for some little time had used it with good effect; it had the disadvantage of possessing a disagreeable odor. It invariably stopped the pityriasis, and its use was frequently followed by a renewed growth of hair, that is, where the pityriasis was a constant feature of the case, but when the pityriasis was not present, there was little or no benefit derived from its use. The question then occurred whether he could not obtain something to take the place of the sulphur and tar. Oil of cade was first used, and afterward oleum rusci, but it is difficult to obtain genuine oleum rusci; then oil of lavender and oil of eucalyptus were used, but it is also difficult to get the latter oil free from turpentine. Naphthol was also used without benefit. The

preparation finally made use of was \mathcal{R} Picis liquidæ, Olei lavendulæ, āā \mathfrak{z} i.; Olei pinî sylvestris, \mathfrak{z} vi., M, though in some cases, in the commencement, a little sulphur is employed.

Before concluding his remarks, Dr. P. said he wished to call particular attention to the following points:

Is the disease in its nature parasitic?

Are parasiticides the best remedies to combat the disease with?

If so, what are the best parasiticides?

DR. MORROW remarked that the parasitic nature of the form of alopecia described by Dr. Piffard had not been satisfactorily proven. He doubted whether there was a parasitic element present. Certainly it did not manifest the contagious characteristics of a parasitic disease, as it was not communicable under conditions of close contact, as in the case of persons sleeping together. While pityriasis of the scalp was commonly present or had preceded premature baldness, he had seen many cases of alopecia in which this condition had never existed. On the other hand, many persons have an abundant pityriasis whose hair is thick and luxuriant. He had used the combination of ol. rusci, ol. eucalypti, and ol. terebinthinæ spoken of by Piffard, but with negative results, possibly because the use of the preparation had not been sufficiently long continued. The treatment he commonly employed was the use of salicylated vaseline, two per cent, followed by the application of equal parts of coal-oil and alcohol.

DR. BRONSON said that he would take exception to Dr. Piffard's use of the term alopecia præmatura. He believed that the variety of alopecia known as præmatura, or *presenilis*, corresponded precisely in its pathology to alopecia senilis, differing from it only in that the cutaneous atrophy to which it was due commenced at an earlier period than usual: while alopecia pityrodes, or *furfuracea*, was rather a disease essentially affecting the corneous structures of the skin, including both the hairs and epidermis. In one case, we have to do primarily with an atrophy of the deeper structure of the skin, while in the other the lesion was a form of keratolysis. He believed the disease under consideration to vary very little from *seborrhœa sicca*. He did not think that the parasitic nature of the disease was well made out, and that it did not follow the ordinary course of parasitic affections. He was in the habit of using remedies which produced an alterative effect on the skin, such as salicylic acid, sulphur, and mercurials.

DR. TAYLOR could not find a parasite in any of the forms of alopecia. He had used a bichloride-of-mercury solution, in the proportion of two grains to the ounce of water, after proper frictions with green soap, and had had excellent results, the hair growing and the pityriasis disappearing.

DR. JACKSON said that the experiment of Lassar and Bishop, and the observations of Malassez and others, would seem to indicate the contagious and possibly parasitic nature of alopecia *furfuracea* or *pityrodes*. It should be remembered, however, that another French observer had claimed to have found upon a napkin, hung up in a damp corner of his laboratory, fungi identical with those of Malassez. As yet, the contagiousness of alopecia is not proven. In regard to treatment, he had obtained excellent results in a number of cases where there was thinning of the hair, with marked pityriasis, from the use of an ointment composed of one part of sulphur lotum to seven parts of vaseline. At first this was rubbed into the scalp every night; later, every second or third night, and thus gradually decreased. Besides this, he directed the patient to wash the head every week with the tincture of green soap.

Though not included under the heading for the discussion for the evening, he would say that he recently had had the satisfaction of seeing the hair grow upon the patches of alopecia areata in a case under his care, after two weeks' use of a wash of three parts of corrosive sublimate to one thousand parts of water, rubbed in twice a day. He recognized the fact that in this disease the hair came in its own good time with or without treatment, and did not wish to claim too much credit for the remedy used. He likewise had had good success in two cases of alopecia areata from a twenty-per-cent pomade of jaborandi, rubbed in twice a day. This pomade he had also used in alopecia præmatura, but without benefit.

In regard to the mange, he had greatly benefited one case occurring in a mastiff by the use of oil of tar. The disease was of the dry, slightly scaly variety spoken of by Dr. Piffard. The case passed from his observation, and he could not say what the final result was.

DR. SHERWELL said that he had never noticed the connection between pityria-

sis and alopecia, nor had he recognized its parasitic nature. In treating premature baldness he often used tarry preparations, and had employed a mild bichloride-of-mercury solution, not for its parasiticide action, but because it possesses the property of stimulating the glands and increasing the proliferating power of the hair-follicles.

DR. ALEXANDER said that, some time ago, he had been asked to see the llamas in Central Park, who were suffering from a form of alopecia, the hair falling in tufts. In the scales at the bottom of the tufts he found a parasite resembling the *acarus scabiei*.

DR. STURGIS believed that baldness might arise from pityriasis without there being any parasite. He believed that many dog fanciers held that mange was not a parasite, and a common remedy with them was turpeth mineral, the subsulphate of mercury; this was of decided benefit, because of the stimulating and parasitic properties which it possessed. He said that it was difficult to believe that mange could be transmitted from one dog to another if it were merely a pityriasis and not of parasitic origin.

DR. KEYES said that he was inclined to believe alopecia prematura to be hereditary in some families, and mentioned a family in whom the father and two sons became bald at an early age, always in the same places. Now, if the disease were parasitic, it seemed to him that the parasite must have some peculiar method of selecting identical situations in different individuals. In the persons mentioned, pityriasis preceded the falling of the hair, and there was pityriasis of the beard, but in the latter situation the hair was very thick. The female members of the family had luxuriant heads of hair. He had tried various remedies, among others hypodermic injections of pilocarpine, one-fifth of a grain of the muriate, with no effect on the growth of the hair.

DR. ROBINSON did not think that it was absolutely proven that the lesion depended upon the presence of a parasite. He believed that the scaly condition seen in cases of alopecia prematura was due to the condition of the patient, and also that the sebaceous glands are affected in the disease. He had used sulphur, according to the method advocated by Unna without benefit, and also given general treatment.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

(From our Special Correspondent.)

REPORT OF THE DEPARTMENT FOR DISEASES OF THE SKIN IN ST. THOMAS' HOSPITAL.—LESIONS OF THE NERVOUS SYSTEM ETIOLOGICALLY RELATED TO CUTANEOUS DISEASES—CASE OF URTICARIA PIGMENTOSA—ERYTHEMA MULTIFORME—PURPURA—BROMIDE ERUPTION—SYMMETRICAL GANGRENE—LEPROUS INFILTRATION OF THE EPIGLOTTIS—MYXŒDEMA—OLEATES—JEQUIRITY IN DISEASES OF THE SKIN—TREATMENT OF SYPHILIS—NEW METHODS IN THE TREATMENT OF DISEASES OF THE SKIN—THE TREATMENT OF RINGWORM.

ACCOUNTS of the out-patients treated during a year in the special departments of our hospitals are, in some cases, little more than a statistical enumeration, and are hence very liable to be passed over by readers as somewhat dry records of no great interest; it is to be hoped that Dr. Payne's "Report of the Department for Diseases of the Skin in St. Thomas's Hospital, 1883" ("St. Thomas's Hosp. Reports," Vol. XIII.), will not share their common fate, as it contains much matter of interest. Impetigo contagiosa is fully treated of, eighty-six cases having applied during the year; it was found to be in frequent association with purulent inflamma-

tions, viz., conjunctivitis, otorrhea, vaginitis, purulent discharge from nose, and ulcerative stomatitis, and with unhealthy suppurating wounds. Dr. Payne believes that a morbid poison causes the disease, and finds a favorable soil in the tissues of cachectic persons, especially children, and has found micrococci in the serous fluid of recent vesicles. Psoriasis is not considered to be connected with gout, as it is common in countries where the latter is rare, and "it hardly logical to assume that what occurs rarely is the cause of what occurs commonly," the occasional co-existence of both diseases in the same person being probably a coincidence only. Heredity was traced in one out of every four cases. Lichen circumscriptus is said not to be very uncommon, and seems to be connected with the wearing of woollen garments next the skin; no fungus could be found on microscopical examination. On the difficult question of the nature of lupus erythematosus, which the author would prefer to call "Cazenave's Disease," he expresses the opinion that the affinity with lupus, though asserted by eminent authorities, remains to be proved. The paper concludes with a full account of a remarkable case of xanthelasma multiplex.

"Lesions of the Nervous System Etiologically Related to Cutaneous Disease" (*Brain*, Oct., p. 342) is the title of a paper by Dr. Radcliffe Crocker, in which he gives a long and careful review of the present state of our knowledge, based on the works of Erb, Schwimmer, Charcot, Leloir, Weir Mitchell, and others. He comes to the conclusion that less serious consequences ensue from cutting off the nervous supply than from irritant or inflammatory lesions of parts of the nervous system that affect the skin; that the kind of eruption produced by the nervous system varies greatly, often without evident reason, when the nervous defect is apparently the same in place and kind; that the same eruption may owe its origin to any defective link in the nervous chain, from the centre to the periphery; that the same kind of nervous lesion that at one time appears to excite an eruption or other nutritive defect in the skin, more often produces no change at all; that lesions other than atrophy which result when innervation is abolished are often traceable to external injurious influences, which the tissues, when unprotected by the nervous system, are unable to resist; but we know nothing of the conditions which determine the nature of the eruption or other skin defect when the nerve lesion is irritative, nor what it is that determines whether there shall be any eruption, or none at all; this uncertainty of effect suggests that the nervous influence is indirect. The cerebral effect appears to vary according to whether its control over the vaso-motor centre is increased or decreased, and according to the secondary changes it induces in the cord; no localizing lesions have yet been found for its influence on the vaso-motor centre. In the spinal cord the fibres that preside over the nutrition of the skin are bound up with the sensory fibres, and are therefore mainly in the posterior columns; outside the cord the path is by the posterior roots, the spinal ganglia, and the sensory fibres, and that lesions of any one or more of these may lead to changes in the skin.

Urticaria Pigmentosa.—A drawing of a "Case of Urticaria Pigmentosa," was shown by Dr. Radcliffe Crocker to the Clinical Society, on Oct. 10. The patient was a girl, four and a half months old, in whom the disease had begun at the age of three weeks, coming out at first as tubercles, singly or in groups. Each lesion was the size of a small pea, yellowish-brown, with a pink areola; on some a small bulla was formed, the contents of which were absorbed in a few days, leaving a permanent tubercle of a yellowish-red color, varying in size. When seen they were found to be from a hempseed to a bean, and brownish-red

to pale fawn, the older ones being paler; itching was not present at first, but had been so latterly. The eruption covered every part of the body, including the palms and soles, but was thickest on the trunk and neck; a few shrank a little, but most remained unaltered, except that fresh vesicles formed on some; there were never any ordinary wheals, nor was factitious urticaria present. The child died of bronchitis eight months after it was first seen, but signs of improvement in the skin had commenced about a month before death. Dr. Crocker remarked that while cases like this were very unlike urticaria, they were brought into closer relationship with that disease by intermediate cases; moreover, nearly every one of the special features of urticaria pigmentosa was seen in exceptional cases of ordinary urticaria.

Erythema Multiforme.—Dr. Spencer's "Notes of a Case of Erythema Multiforme" (*Brit. Med. Journal*, Sept. 6, p. 465), describe a case occurring in an anemic blonde girl, aged 19, presenting the usual characters of the eruption, and subsiding in twelve days, followed by branny desquamation; but there was considerable fever, the highest point reached being 104° on the ninth day, and the highest pulse rate 130 on the eleventh day. As the eruption was preceded by severe lumbar pain, variola was at first suspected, a suspicion which was soon set at rest by the absence of pustulation and the character of the rash.

Purpura.—An interesting case of "Purpura" was communicated to the Pathological Society by Dr. Wickham Legg, on Oct. 21. He showed preparations of the tissues from a man, aged 36, who had syphilis two years before his death, and was also a free drinker; for six months before death he had undergone considerable privation, and had had little vegetable food; he had a rash, probably purpuric, which increased about three weeks before he died, with vomiting and diarrhoea. On admission, there was well-marked purpura over the whole body except the face, and swellings of the joints; both decreased at first, but a recrudescence of the purpura took place accompanied by urticaria, hæmorrhage taking place into the wheals in a few hours; this eruption began at one elbow, and spread over the whole body. At the necropsy extensive ulceration of the intestines was found, beginning four feet from the duodenum and extending to the rectum; this was not uncommon in fatal purpura. Microscopical examination showed great numbers of colored corpuscles in the connective tissue of the skin, and around and within the sweat-glands, hair-follicles, and sebaceous glands; there were also large masses of colored corpuscles so disposed as to make it probable that they were caused by ruptured vessels; in the papillæ and close under the epidermis, the vessels were distended and full of blood; the outer and middle coats of the arteries in the areolar tissue were infiltrated and much thickened. Dr. Legg said that against scurvy, there was no swelling of gums and no improvement under treatment; against alcohol, no changes in the liver; the swelling of the joints was in favor of rheumatism, as was also the purpura urticans, but the disease of the vessels was against this view; he thought this and the purpura were due to syphilis. Dr. Wilson Fox had recorded one case of purpura occurring in combination with syphilis, in which he had found the same changes in the blood-vessels of the skin. Dr. Buzzard said he did not think the case was scurvy, and had never seen such a condition in syphilis, but had met with it in purpura from alcohol.

Bromide Eruption.—Dr. Carrington showed a drawing of "Bromide Eruption" to the Clinical Society, on Oct. 24. The child was born healthy, and remained so to the age of ten months; it then began to suffer from convulsions and symptoms which seemed to point to meningitis, and was given a mixture con-

taining a little more than one grain of bromide of potassium in each dose, every four hours; for a time it was given every three hours, and for a time bromide of ammonium was substituted. The medicine was persisted in for about seven weeks. The eruption appeared as small red papules, which in three or four days became the size of penny-pieces, and the parts affected were the buttocks, legs, and thighs, and to a lesser extent the scalp and face; the smaller spots were bright red and smooth, the largest dark brownish, circular or elliptical, with a sharply defined edge at least one-eighth of an inch in thickness; they were spongy, but without fluid contents. The treatment was half a grain of iodide of potassium and one minim of Fowler's solution, three times a day; in a fortnight there was great improvement, some spots had disappeared, and were represented only by pinkish discolorations, and the others were much shrunken, and nearly on a level with the skin; no new ones appeared, and recovery was uninterrupted. Dr. Duckworth thought this case remarkable as the sebaceous glands were not specially involved. Dr. Stephen Mackenzie said the appearance of the eruption might be deferred till some time after beginning the drug, and might continue two or three weeks after its cessation. Dr. Barlow corroborated this, and thought the explanation was the existence of an individual idiosyncrasy preventing due elimination of the drug; he had seen the rash occur three weeks after the medicine was stopped, and the urine then contained bromine. Mr. Marrant Baker pointed out that the worst cases of iodide rash occurred in patients with advanced kidney disease, and Sir Andrew Clark said this was a frequent cause of the retention of certain drugs in the system for a lengthened period.

Symmetrical Gangrene.—Mr. Young showed a case of "symmetrical gangrene" to the Manchester Medical Society, on Oct. 1. The patient was a man aged 21, with gangrene of almost the whole of the distal phalanges of the fingers on each hand; beyond abnormally smooth and glossy skin, the thumbs were unaffected. Onset was characterized by intense pain and lividity, before which the fingers became very cold and pale, were more or less numb, and there was some loss of power. The patient was very anæmic, and had always been weak, and suffered from cold extremities, but was otherwise healthy; the organs and secretions were found healthy, but the blood contained an excess of colorless corpuscles; the family history pointed to a probability of inherited syphilis, of which, however, he showed no sign beyond slight deafness.

Leprous Infiltration of the Epiglottis.—A valuable "Report on Leprous Infiltration of the Epiglottis, and its Dependence on the Bacillus Lepreæ," has been issued by Dr. Thin (*Brit. Med. Journ.*, July 19, p. 109). He shows that the special habitat of the bacillus is the lymph or colorless blood-corpuscle, as proved by the occurrence of cells containing bacilli within lymphatics and blood-vessels, and does not doubt that the large leprous cells found in the connective tissues, and largely forming the nodules of leprosy, are due to a slow growth of migratory cells infected with the bacillus. In the epiglottis the cartilage and epithelium were found uninvaded by the leprous growth. The paper is illustrated with six excellent woodcuts, and gives details as to the best mode of demonstration.

Myxœdema.—The subject of "Myxœdema" continues to attract attention. Dr. McCall Anderson has recorded a case (*Glasgow Med. Journ.*, Oct., p. 303) which was very considerably improved by the following treatment: the patient was shampooed daily for half an hour, olive oil being used; every third day she had alternately the following: 1st day, vapor bath; 2d day, pilocarpine gr. $\frac{1}{4}$ hypodermically; 3d day, a hot electric bath for half an hour; she also took a mixture of

arsenic and strychnia. Each of the above three methods made her sweat profusely. The electric baths were stopped after six weeks, and in less than three months she left the hospital much better. Dr. Donald Fraser's "Case of Myxœdema with recovery, which was marked by profuse perspiration" (*Med. Times and Gazette*, Oct. 25, p. 572), was most remarkable, as the sweating, which was extremely profuse, was quite spontaneous, and seems to have continued for two years. At the Clinical Society, on Oct. 24, notes of a case of Myxœdema were read by Dr. James Anderson. It occurred in a married woman, aged 40, and was of twelve years' duration. The points of interest were (1) a history of commencement from hemorrhage after extraction of teeth, lasting twenty-four hours, and a general hæmorrhagic tendency, shown by menorrhagia and bleeding of the gums; (2) an occasional state of nervous restlessness, apparently incompatible with the general character of the disease; (3) the ocular condition; she was slightly hypermetropic, had slight peripheral opacity of the left lens, and both retinæ presented a hazy appearance surrounding the vessels, especially in the neighborhood of the disc; the appearances differed entirely from those of past neuritis or retinitis, and did not interfere with perfect vision; (4) she felt greatly better after jaborandi, although there was no apparent improvement in her outward condition, but there was a steady and marked increase in the amount of urea excreted, which doubled itself during treatment. In the discussion, Dr. Sémon referred to the effects observed to follow excision of the thyroid by Kocher, and especially arrest of growth when the operation had been performed before development of the body was completed; recently this had been confirmed by Prof. Bruns, in the case of a patient, aged 28, whose thyroid had been removed eighteen years before on account of goitrous degeneration; growth in length had been entirely arrested since the operation, and he had become a cretinous dwarf, only the dimensions of the head being those of a man of his age; he presented the character of myxœdema and also that of cretinism, and obviously both were connected with loss of the function of the thyroid. Dr. Hale White referred to the necropsy of a case (communicated in full to the Society on Feb. 13) in which marked degeneration of the thyroid was found, and he considered this to be the cause of the disease, because all the other changes were probably secondary. In connection with this subject, Mr. Victor Horsley's lecture on "The Thyroid Gland: its Relation to the Pathology of Myxœdema and Cretinism, etc." (*Brit. Med. Journ.*, Jan. 17, p. 111), may be referred to. He found that extirpation of the body in monkeys gave rise to peculiar psychical and somatic changes which were closely analogous to those of myxœdema.

A variety of therapeutical papers have recently appeared. Dr. Shoemaker, of Philadelphia, has written on "Oleates, further investigations into their nature and uses" (*Brit. Med. Journ.*, Oct. 18, p. 749); on "Jequirity in Diseases of the Skin" (*Lancet*, Aug. 2, p. 185), and on "the Treatment of Syphilis" (*Lancet*, Sept. 6, p. 406). The latter subject forms a large part of Mr. Alfred Cooper's paper on "Syphilis, its prevalence, nature, and treatment" (*Brit. Med. Journ.*, Oct. 18, p. 755). He regards excision of the primary induration as useless, as it is the local manifestation of constitutional infection, and thinks the earlier mercury is given the better, and that the most convenient way is to give blue pill by the mouth; mercurial treatment should be prolonged over two years, with intervals of discontinuance, and he thinks no patient should be allowed to marry until he has undergone such a course, and has subsequently remained free from symptoms for a year at least.

"The Treatment of Ringworm" forms the subject of several short notes

and memoranda. Dr. Alex. Smith (*Brit. Med. Jour.*, Nov. 1, p. 858) still thinks oleate of mercury one of the best remedies for chronic cases, but has not had much success with oleate of copper. He has lately been trying what vehicle penetrates most deeply into the hair-follicles, and thinks it is chloroform, which dissolves out the fatty matter. During the last year he has used a solution of seven grains chrysophanic acid (chrysarobin) to the ounce of chloroform in all cases of recent ringworm, and believes it is the most efficient treatment he has yet tried. The small patches should be carefully marked out by cutting the hair very closely over them, and the solution should be well pressed and dabbed into the places with a minute sponge mop for five minutes two or three times a day, according to the amount of irritation produced, the aim being not to produce scabs, but to get the solution to penetrate deeply. The mop should not be much larger than a big pea, and should be continually dipped into the chloroform bottle, as the solution soon evaporates and leaves the yellow acid dry on the place. Great care must be taken that the solution does not run on to the forehead or into the eyes, and that the person using it does not inhale the vapor; he always gives full directions about the care necessary, and only employs it to small places of the disease. The places should be well washed every morning with hot soap and water, to remove any sebaceous matter or crusts, and the hair should be kept closely cut until new hair appears, generally two or three months; but the remedy should be continued till all diseased stumps have come out. Mr. Malcolm Morris (*Brit. Med. Journ.*, Nov. 15, p. 961) points out that he had recommended chloroform as a solvent in 1881 and several times subsequently. He has used various drugs, as thymol, salicylic acid, boracic acid, perchloride of mercury, etc., in chloroform, in ether, and in spirits of wine, and believes that cases yield more readily to this than any other treatment. Almost all authorities recommend washing the scalp with hot soap and water, but he has found that this often conduces to the spreading of the disease; for the last year or more he has always given strict injunctions that the scalp is not to be touched with water or soap. It is easy to understand that sporèe can be carried from one part of the head to another in soap and water, and so propagate the disease. Dr. Bernard (*Brit. Med. Journ.*, Nov. 22, p. 1,013) cannot agree that washing the scalp is prejudicial. In one very severe case, after trying perchloride and oleate of mercury, chrysophanic acid, and sulphurous acid, he gave up all active treatment, relying solely on washing the head twice a day and sometimes oftener with soft soap and tepid water. The result was most satisfactory: in a comparatively short time the disease gave way, the bald patches soon becoming covered with hair; he thinks petroleum useful. Dr. R. Liveing (*Brit. Med. Journ.*, Dec. 13, p. 1189) used oleate of copper about two years ago as a soft ointment in over 100 cases; it was fairly tried for a year, but the result did not come up to his expectations, and he concluded that it was not equal to oleate of mercury as a curative agent. There was also the less serious drawback that the friends objected to the brilliant color of the ointment, which called attention to the fact of the children having ringworm, although, in one sense, this was an advantage. Subsequently he used an ointment of soft soap and salicylic acid (3 ss. to 3 i. in 3 i.); this turns brown if kept long and is moderately successful. In 1871 he recommended hyposulphite of soda lotion (3 i. to 3 iss. in 3 i.) as a useful watery application, and still thinks it the best of its kind. With regard to washing, when an ointment is being used it is usually better not to wash the head very often, because then the ointment does not penetrate so well as when the head is only washed once a week. Free washing with soap and water is a good preventive, and he

often advises parents who have ringworm in their family to wash daily the heads of those children who have as yet escaped the disease, and has scarcely ever known ringworm spread when this is carefully carried out. Hebra used to treat ringworm with soft soap. Ringworm is unwittingly propagated by hair-dressers; children with the disease (both known and unknown) are constantly taken to have their hair cut, a brush and comb are used, and then used again for the next customer, who may happen to be a child. The only safe plan when children are taken to have their hair cut is to take also a comb and brush, the latter being the most dangerous in propagating the disease. In a further communication on the same subject (*Brit. Med. Journ.*, Jan., 17, p. 126), Dr. Alder Smith points out that it is common for children who have ringworm to be taken to the latter, and to be allowed to try on numerous caps, which may thus become sources of infection. The most important point to remember is, however, the fact that many children are still permitted to mix freely, in schools and elsewhere, who have chronic uncured, and often untreated ringworm of the head. He gives the result of examination of boys presented for admission to the large school of Christ's Hospital for a period of ten years; no less than eight per cent of the applicants, aged between 8 and 10, had ringworm of the head, and, as a rule, unknown to their parents. Many of these children are rejected a second, third, or even a tenth time, but many of them had been attending other schools, and had certainly been mixing with other children.

CAVAFY.

LONDON.

Selections.

THE ETIOLOGICAL RELATIONS BETWEEN SYPHILIS AND TABES DORSALIS.

THE author's opinion as to the existence of an etiological relation between syphilis and tabes dorsalis was made public several years ago. He is now induced to return to the subject by his observation of two cases possessing more than ordinary interest in connection with it. The first of these came under his care last summer, in the person of a very intelligent merchant of middle age. The ataxic symptoms had made their appearance three or four years before, and were now strongly marked. Although the patient's general strength was undiminished, he could get about only with the aid of a cane, stepping unsteadily with a kind of "spring-halt." When standing with [his eyes shut he swayed about heavily. Tendon-reflexes entirely absent; single movements jerking and uncontrollable. There were also ischuria, necessitating frequent catheterism, nocturnal enuresis, and complete impotence. Strabismus and diplopia had existed for about six weeks, having preceded the full development of the ataxy. As causal influences in this case, heredity, depressing emotions, and over exertion of the limbs were certainly excluded. The patient could give no history of undue exposure to cold. He was himself inclined to attribute his disorder to sexual excesses, but as these had been confined to the period of youth, and he had been happily married for seventeen years, I was compelled to disagree with him. In 1865, how-

ever, he had contracted an indurated chancre. This, as well as another which appeared subsequently in its neighborhood, had healed in about six weeks under local treatment and the internal administration of mercury. It was not until 1870 that constitutional symptoms began to be noticed. They consisted of ulcers in the nostrils—which occupied two years in healing—a perforation of the nasal septum, and gummata in the face, and constituted the first links in an almost unbroken chain of syphilitic phenomena which extended over fourteen years. After ten years of this general contamination, appeared the precursory signs of what by degrees was developed into a typical form of tabes dorsalis. *The idea of an etiological connection in this case between the specific malady—ultimately so formidable, though so mild at the outset that its earliest manifestations were evidently overlooked—and the disease of the spinal cord, is one which must have occurred to any physician.*

The second case possesses greater significance. On the twentieth of March last, a journeyman blacksmith aged 72, presented himself at my clinic. He was in a greatly reduced condition, and exhibited in a marked degree the three characteristic symptoms of restiform degeneration of the posterior cord, viz., *unsteadiness of gait, with disorderly movements; swaying about when the eyes were shut, and abolition of the patellar tendon-reflex.* In addition, his lower extremities were almost insensible to contact, while apparently retaining their perceptions of temperature and pain. The functions of the upper limbs were fully preserved, and the territory of the cerebral nerves had almost escaped invasion. In the sulcus behind the glans penis was a small cicatrix with clear periphery. The lungs and bowels were in an advanced stage of tuberculosis. The following history was elicited: "Since his apprenticeship the patient has suffered from rheumatism in his limbs, brought on by the exposure incident to his occupation, but during the past twenty years the pains have seldom been experienced. The first symptoms of tabes dorsalis—*numbness and formication of the legs*—date from two years ago. They were soon succeeded by unsteadiness in the dark, with danger of falling; his legs, also, easily became fatigued, and his gait was uncertain in the daytime, so that he was obliged to give up his work. Four years ago, however, as we learned from his former employers, he was able to stand firmly and walk long distances. The lung troubles have lasted a year; abdominal pains with bloody stools, only a few months. Four years ago—*i. e.*, at the age of 68—he contracted syphilis, for which he underwent treatment at the Breslau Dispensary for Venereal and Skin Diseases. The dispensary records show that he was admitted Oct. 25, 1880, and discharged as cured on the 19th of the following month. 'Diagnosis. Lues; Sclerosis; exanthema maculo-papulosum.'" The post-mortem examination on the second of last May disclosed, beyond the slightest doubt, a typical degeneration of the posterior columns of the spinal cord.

While not presenting the above case as direct proof of an etiological connection between syphilis and tabes, I would ask whether it does not suggest a forcible warning against wholly excluding the possibility of such connection, as certain prominent authorities have attempted to do. In this patient we have seen that the first decided symptoms of the spinal affection were manifested when he was 70 years old, and a few months later unmistakable ataxic phenomena supervened. The development of tabes dorsalis at so advanced a period of life is an extremely rare occurrence—that is, *when its existence is afterwards anatomically demonstrated.* Every single influence which can give rise to the disease was found to have been inoperative in this instance, until the patient had reached an age which might almost have been supposed to guarantee his exemption. After an

attack of intermittent in 1868, he continued in perfect health down to 1880, when he contracted syphilis. Such an accident, occurring to so old a man, naturally gave rise to a suspicion that sexual excesses might have contributed to the final result; but this hypothesis was steadily contradicted by the patient. *Under these circumstances, may we not be justified in regarding an etiological connection between the affection of the posterior cord and the specific disease, contracted three and one-half years before death, as possible, to say the very least?*

The greatly diminished severity of the secondary symptoms in cases of tabes dorsalis with syphilitic antecedents has been noticed by various authors.

The *statistical estimate* which I next proceed to exhibit is based upon one hundred hitherto unpublished cases selected from my clinical records, and including none but unquestionable instances of typical tabes dorsalis, in which the presence or absence of syphilitic antecedents had been thoroughly ascertained. In fourteen out of these one hundred cases, the diagnosis of restiform degeneration of the posterior cord had been confirmed by post-mortem examinations, which in five of the fourteen had also established the pre-existence of syphilis. Of the one hundred tabetic patients, forty-three had suffered from secondary symptoms. The mean length of time which elapsed between the onset of syphilis and the earliest ataxic phenomena was about eight and a half years. From a clinical point of view, no difference whatever was discernible between tabes dorsalis in the syphilitic and in the non-syphilitic subjects. Since this disease always depends essentially upon a restiform degeneration of the posterior cord, it would be as unreasonable to expect that its symptoms should vary according to its mode of origin, as to look for a similar difference between cases of cirrhosis of the liver, when due respectively to syphilis and to alcohol. And in neither instance can the non-success of anti-specific treatment be accepted as important evidence.

The above statement is claimed to be the result of careful and scientific scrutiny. Against the valuation which I would place upon it, but one plausible objection can be urged, viz., that the total number, 100, is too small to warrant a definite conclusion. But many trustworthy observers, more especially Erb, have reported even a higher percentage of syphilis than this among tabetics, while opposing estimates have been founded for the most part upon statistics drawn from an earlier period, when patients were subjected to no special examination as to their syphilitic antecedents. If it be alleged that the 43 per cent of syphilis upon which I rely is no larger a proportion than may be found unassociated with tabes, I can point to the result of special investigations showing that, among male subjects at large, between the ages of 25 and 40, both those in good health and those laboring under any kind of disease excepting syphilis, only 12 per cent had ever had the latter. Erb, among 1,200 males over 25, found only 10 per cent of syphilis. This difference appears to me so strongly marked as to render a causal connection between syphilis and tabes exceedingly probable. *Forty-three per cent of secondary syphilis among non-tabetics is a proportion absolutely unheard of in this country.*

I am aware that there are some who deprecate the numerical method as applied to the solution of this important question, and who call for clinical and anatomical proofs. It has been already explained why the former mode of demonstration is not applicable in the present case. Pathological anatomy is also inadequate to its requirements. Microscopical examinations have shown conclusively that there is no such thing as a peculiarly syphilitic affection of the posterior columns. Yet, although specific disease cannot be regarded as a direct cause of the medullary sclerosis, it is very prob-

ably etiologically connected with it in another way. It is readily conceivable and appears in fact to have been proved by recent investigations, that syphilis, which so destructively affects the blood-vessels of the brain, is also not without its influence upon those of the spinal cord. If this be so, the disease will result in lessening the resisting capability of the cord, and perhaps this lessening process may take place before any alteration of the vascular structure is anatomically discoverable. Under such conditions, exposure to cold, excessive fatigue, and other causes which undoubtedly tend to impairment of the cord, will, in many cases, be borne without detriment to the latter, owing to slight compensatory changes which take place within its substance. The occurrence of such compensation must largely depend upon a healthy functional condition of the vessels concerned—and thus we see how syphilis may act by rendering the cord more subject to hurtful impressions—in short, by endowing it to some extent with a *specific predisposition*. The lowering effects of syphilis upon the system at large need not here be considered, since many patients in the earlier period of *tabes* enjoy the fullest constitutional vigor. Since, as we have seen, the spinal cord, in “syphilitic *tabes*,” is not specifically affected in any direct manner, and even in the initial stage of the complaint has already undergone a deep-seated process of degeneration, it is not surprising that anti-syphilitic treatment has shown but little efficacy in this direction. According to my experience, *tabetic patients with atrophy of the optic nerve bear mercury badly*. In other cases, we shall be able to avoid any evil results from the remedy, by administering it in strict accordance with constitutional peculiarities. But few “cures” of *tabes dorsalis* by anti-syphilitic measures are on record. My own practice has yielded only a single instance of the kind. In 1869, a vigorous, florid-looking officer, thirty years of age, was sent to me by my esteemed friend, Professor Hermann Kohn. In 1863, he had a chancre, which he described as induration, although he could give no account of secondary symptoms. The sore healed in about six weeks, under purely local treatment. When I examined him, he presented a typical case of advanced *tabes dorsalis*, with very considerable ataxia, and a remarkable diminution of tactile sensibility. Within two months, under galvanism and the use of potassic iodide, he was restored to perfect health, and has since been advanced to a higher military position. Not a solitary trace of locomotor disorder is now to be detected. I have no doubt it would be quite correct to say that a “positive cure” has been effected in this case. Yet I do not believe that, even here, a sclerosis of the posterior columns was actually removed, but rather that they had been secondarily involved in a syphilitic affection of their meninges, which mimicked very closely almost all the symptoms of *tabes*.

Since, then, it cannot, with absolute certainty, be determined from the symptoms alone, in every case of locomotor ataxy apparently connected with syphilis, whether the disease consists in an incurable primary degeneration of the posterior cord, or in a curable disturbance of its functions, resulting from specific lesions, anti-syphilitic treatment of the same will always be in order, unless positively contraindicated in some way.—OSCAR BERGER, *Deutsche med. Wochenschrift*, Jan. 1 and 8, 1885.

DANGERS FROM THE EMPLOYMENT OF VULCANIZED RUBBER CLOTH IN THE TREATMENT OF ECZEMA.

DR. JULES SIMON lately advised this method of treatment in the case of an infant five months old, affected with eczema impetiginosum. The disease had invaded the face, forehead, scalp, neck, and upper portions of the back and chest.

After one day's application of the vulcanized cloth, there were burning heat of the head, elevation of bodily temperature, and sleeplessness, while a salivary discharge which had previously been very abundant was almost wholly suppressed. Next day the eruptive surface was of a bright-red color, and bled at every renewal of the dressing. The child was prostrated, its fever was considerably higher, and urination was markedly diminished in amount. On the third day, the debility was extreme, the face had a jaundiced appearance, the features were contracted, and the eyes sunken. On the fourth day, the high temperature was succeeded by coldness, especially of the extremities; and as the symptoms just detailed were attributed by Dr. Simon to the action of sulphide of carbon, which had not been sufficiently removed from the cloth in the process of manufacture, he ordered the material to be replaced by a silken fabric stiffened with gum. From that moment a rapid improvement set in; the child recovered its strength and activity; the eczematous surface ceased bleeding; in ten days there was a gain of 220 grammes in weight, and the eruption gradually disappeared—showing that the employment of silk, under such circumstances, confers the same advantages as that of vulcanized rubber, while free from the dangers accompanying the latter.—*Rev. de Malades de l'Infance*, Nov., 1884 (*Lyon Médical*).

THE MICROPHYTES OF THE NORMAL SKIN, AND THEIR RELATION TO AREA CELSI.

BELIEVERS in the parasitical origin of area Celsi have had to meet the objection that the fungus which they connect with the disease had either not been botanically defined at all, or else, in some cases, had been identified with the *trichophyton tonsurans*, while in others a growth not recognized as sufficiently characteristic had been found in the neighborhood of the affected localities. This, of course, could be replied to very plausibly by demonstrating the presence of a vegetable product at the very bases of the hair-follicles, thus apparently explaining all the peculiarities of area Celsi, the falling of the hair from isolated spots, and the difficulty encountered in treating the disease. It only remained to be determined why the morbid elements were never found in any amount on or about the surface of the diseased parts, since their earliest extension must necessarily take place from that surface downwards. The author now reports that he has examined patches of recently developed area Celsi, which was easily curable by a simple application of carbolic solutions, the disease being thus proved to be still confined to the surface.

He detected in two cases an abundance of superficial spores, from which it might be inferred that the affection actually follows the course just indicated. The discovery, however, of precisely similar spores on healthy scalps, forbids the positive assertion of a causal connection between those products and area Celsi. On the other hand, it leaves the idea of such a connection still unrefuted, and although tropho-neurotic cases of area are undoubtedly met with, yet the simultaneous occurrence of the complaint among individuals respectively belonging to the same family, the same school, the same locality, or subject to the same conditions in other respects, speaks strongly in favor of its parasitical nature—which, of course, can be finally made manifest only by scientific culture and inoculation of the fungi.—C. PELLIZZARI, *Bollet. della Soc. Tra I. Cultura della Sci. Med. in Siena*, II., 1884 (*Wien. Med. Wochenschr.*).



Dr. Hyde's case of congenital *nævus*
lipomatosus.

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A CASE OF CONGENITAL NÆVUS LIPOMATODES.

BY

JAMES NEVINS HYDE,

Chicago.

ON the 3d of October, 1883, P. F., æt. 3 years, was brought to me by his parents, each of whom presented the usual appearance of sound health. The father was forty-eight years old, and gave no history of illness save that, a few years before, he had suffered from a mild attack of rheumatism. The mother, forty-one years old, stated that she had always been well. Of their four children, two besides the one whose case is here reported were then living. All were physically perfect and in sound health. One child had died in infancy of a disorder which they could not definitely describe. The family history was minutely investigated as far as the paternal and maternal grandparents of the child, its uncles and aunts on both sides, and the children born to one sister of the mother. In none were there traces of disease or of deformity.

As may be generally expected in such cases, there was, in the present instance, a history of ante-natal maternal impression. The mother said that early in the pregnancy which resulted in the birth of this child, she had been "kicked by a cow." She referred the deformity of her infant to this accident alone. The child had been, when it first came into the world, deformed, and in very nearly the condition presented at the date of the examination, the only difference to be recognized depending upon the slight deepening in the shade of color of the pigmented patches, the increase in the pilary growth, and the development of the tumors as the body of the child increased in size.

The parents added that the boy was in excellent health, occasionally not sleeping very soundly, the only point which they could name as indicative of any perversion from the standard observed in the case of their other children. Since birth, it had regularly gained in weight. They sought advice solely on account of their desire to relieve the disfigurement, and were emphatic in refusing to permit the use of the knife, either for the removal of the tumors or for the purpose of securing small segments for minute examination of their structure. They consented, however, to permit photography; and the excellent impression from which the accompanying cut is made was taken by my colleague, Dr. Fred. W. Mercer. An appointment was made with the parents in order to exhibit the case to the students at my clinic at the college; but fearful lest any operative procedure might be there attempted, they at once carried the child from the city to its home in Wisconsin.

When examined, it was found to be a male child, having the proper development for its years, and fairly well nourished. On its face were twenty pea to bean sized, light-brownish, superficial, and circular pigmented moles, not provided as yet with hairs. Similar discrete, and almost symmetrically disposed blemishes were visible upon the scalp, shoulders, chest, and upon the surface of the tumors described below. None were found below the ankles.

The lower part of the trunk and a portion of both thighs was the seat of an enormous lipomatous and pigmented mole. The surface over which it extended was nearly that usually covered by a pair of swimming drawers, drawn high up over the back and belly, and reaching unequally down over the thighs. The border of this was clearly defined above in an almost symmetrical sweep, extending behind from near the spine of the sixth dorsal vertebra, in a gentle curve whose concavity was upward to a point somewhat below the umbilicus in front. Below and in front, the line of demarcation was quite distinct in the lower fourth of the thighs, and nearly at the same level in each. Posteriorly, the limit was about the same on the left thigh and indeterminate on the right, where the lipomatous tumors existed. This mole was in general of a dark-chocolate color and provided with soft hairs, averaging in length two inches.

The tumor or tumors connected with this *nævus* existed for the most part on the right side and over the right flank and buttock. On the left were several smaller growths, large nut to turkey's egg in size, the largest just to the left of the upper limit of the cleft of the nates; another, smaller, at the level of the first dorsal vertebra near the internal border of the fleshy part of the *latissimus dorsi*. The smallest of these elevations above the general level were scattered irregularly over the left buttock, loin, and thigh, both in front and behind.

On the right side, the sessile and pedunculated, partly pendulous growth might be regarded as a lobulated single tumor, or as composed of several similarly constituted growths. In general, this mass lay over the loin and buttock behind, but, viewed anteriorly, the projecting outline became plainly visible, as three distinct projections from the contour of the right side of the trunk and thigh. Measured in totality, these lobulations were twenty centimetres in longest transverse, and twenty-three centimetres in largest vertical diameter. The superior lobe or tumor measured eighteen by ten centimetres; the lower eighteen by six. Each was softish on manipulation, having the ordinary feel of a lipoma, covered with larger maculations than those disseminated over the shoulders, face, and other parts of the body mentioned above, and sensitive to the touch, though the child was too young to be tested by the æsthesiometer. Sulci were visible on the summits of the two larger masses, which indicated a tendency to further lobulation, the direction of these being for the most part in a horizontal plane. The S-shaped figure of one of these is seen in the cut.

Below the level of these tumors on the right there was much less distinctness of demarcation. Here an irregular line of pigmented and pilous integument formed the lower limit of the largest nævus.

The smaller as well as the larger tumors exhibited surface pigmentations; and the isolated, sparsely distributed pigmentations below the knee on the left, and over the middle of the right thigh, were more irregular in outline and in cases somewhat larger than those scattered over the upper part of the trunk and the face. The spine was not in lateral deviation, the suggestion of this deformity being due to the position of the child when photographed, and a certain defect in the symmetrical development of the nævus over the dorsal and lumbar spines.

Cases of multiple or extensive pigmentary nævi have been repeatedly recorded in dermatological literature, rarely, however, in such extensive development as in the subject of this sketch. Bärensprung¹ and Theodor Simon² were first to call attention to the surface arrangement of these and other congenital blemishes, vascular, verrucous, atrophic, etc., in the areas supplied by definite nerves. Striking corroborative evidence of their views is furnished by a series of interesting cases collected by Campana,³ the paper in question being illustrated by woodcuts. One of these, osserv. 7, fig. 9, represents a male child, eight years old, with a symmetrically disposed hairy mole, extending nearly from one axilla to

¹ "Nævus Unius Lateris," Ann. des Charit. Krank. B.I. iii., Hft. 2, Berlin, 1863, p. 91.

² "Ueber Nerven-Nævi," Arch. f. Derm. u. Syph., 1872, Hft. 1, p. 24.

³ Giorn. Ital. d. Malatt. Vener. e. d. Pelle, 1876, p. 257. Sopra Alcuni Nèi Materni.

the other on the dorsal surface of the trunk, and reaching from the second dorsal to the last lumbar vertebra.

Cases of unusual multiplicity of pigmented moles have been also observed by T. De Amicis¹ and by myself,² the moles in the last-mentioned case having been curiously arranged upon one side of the body only, in the lines commonly traced by the lesions of zoster affecting the same regions.

Geber³ reports a case where yellowish-brown and roundish spots were seen also upon the scalp.

Paget⁴ records the case of a girl, 12 years of age, whose mother, at some time during the pregnancy preceding her birth, was frightened by a monkey attached to a street hand-organ. In this case, the left upper extremity and the greater part of the same side of the trunk and neck of the child were deeply stained and covered with long harsh hairs, from one to two inches in length.

Still rarer are the mollusciform or lipomatous nævi. Damon in his treatise⁵ does not seem to have known of the more extensive forms of this growth, as his description applies to the smaller varieties only; and several dermatological authors are equally silent as to the possibilities of development in this deformity. Neumann, for example, speaks of the larger lesions as attaining the size of the fist.

Italian observers seem, curiously enough, to have had a more fertile field for observations of this kind. Perhaps the darker race, to which in great part their observations must have been limited, may be allowed to explain the fact. Manassei,⁶ for example, gives an illustration of the back of a female child, covered from the scapulæ to the thighs behind, and from the umbilicus to the same general line anteriorly, with an extensive, brownish and blackish, pigmented mole, covered with hairs. Here and there, over the surface thus involved, were nut-sized lipomatous tubercles. The arms and legs below the cuirass-like mole had bands of similar pigmentations covered with hairs and tuberosities; while smaller pigmentations, circumscribed and roundish, as in the case here illustrated, were sprinkled irregularly over the general surface of the skin.

But certainly most interesting in this connection, Angelo Scarenzio,⁷

¹ *Lo Sperimentale*, Mar., 1876.

² *Chicago Med. Jour. and Exam.*, Oct., 1877.

³ "Ueber eine Selten. Form von Nævi der Autoren," *Viertel. für Derm. u. Syph.*, 1874.

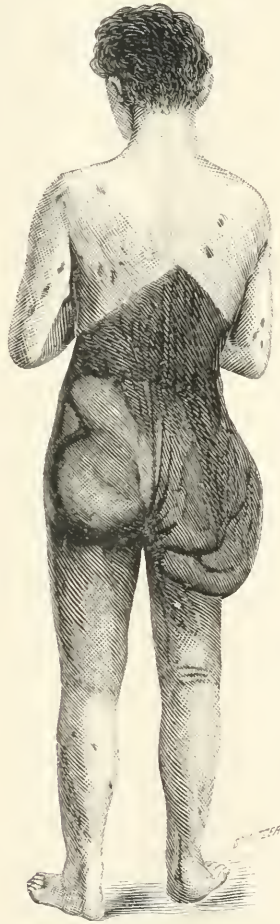
⁴ *Lancet* for 1868; see the *Jour. of Cutan. Med.*, vol. i., 1868, p. 471, observation reported by Smith.

⁵ "Structural Lesions of the Skin," *Phil.*, 1869.

⁶ *Giorn. Ital. d. Malatt. Vener. e. d. Pelle*, 1877, p. 227, "Su di un Caso di Nèò Verrucoso, Pigmentario, Peloso, Congenito."

⁷ *Giorn. Ital. d. Malatt. Vener. e. d. Pelle*, 1877, p. 220, "Di una Singolare Alterazione Pigmentaria, Verrucosa, e Lipomatosa Congenita."

reported an observation of his, to the Royal Institute of Science and Letters in Lombardy, which in many points resembles the features of the case here described. The resemblance is so great that the illustration accompanying his printed report might almost serve as a representation of the child under my observation, after the attainment in the



future of adult years. It is in consequence of this resemblance, and of the practical fact thus suggested, that I have reproduced the cut from the author's original paper. It indicates with sufficient clearness, without a reproduction of the written details of the case, the extent and character of the deformity.

The age of the subject is not given, but it is stated that he was one of a family of eight children, none of whom was similarly disfigured. The

mother, being interrogated, could offer no explanation of the result, save that when pregnant before the birth of this child, she had been greatly disturbed when in the market-place, by her husband not consenting to humor one of her wishes. Frassini, for that was the name of the subject of the sketch, had attained adult years, and presented himself for examination merely to secure exemption from military service. It will be seen that the shoulders are covered with roundish discrete maculations; these also covered the face, and were, at his time of life, tawny-colored and blackish, covered with hairs, and in this region numerous. The gigantic mole figured in the illustration was brownish-black in hue, beginning, above, at about the same point as in my case, and with equally symmetrical curves reaching below the umbilicus in front. The line of demarcation on the left thigh was distinct; irregular below on the right; and the lipomatous growth, lobulated and pendulous, reached in this case also over the right loin and buttock. Pigmented moles, moreover, were visible on the legs below the knees. Scarenzio also discovered two upon the glans penis, in close proximity to the urethra.

These two figures tell their own story, and tell it very plainly. An Italian woman brings into the world a child marked by a rare congenital deformity that is almost reproduced in fac-simile, after nearly a score of years have elapsed, in the child of a woman of German descent, whose pregnancy was conducted and concluded in a distant continent, with a totally different environment. The possibility that peculiarities in the character or circumstances of an impression, made upon the pregnant woman and conveyed to her unborn child, determine the nature of any deformity subsequently apparent in the latter is thus dispelled. The several animals, monkeys, cats, dogs, cows, bats, etc., that have been described as influencing the shade of color, degree of hairiness, and surface arrangement of these moles have evidently no relation whatever with the results. It is probable that the nervous centres of the new being, and of none other, have immediate control over these rare consequences. What influences may be transmitted to such centres, through the umbilical cord, or, at an earlier period of gestation, through the more intimate connection existing between the ovum and the mother, must at present lie in a field where conjecture alone is possible.

It is the part of science, however, to record with distinctness that nature, even in what appears to be her wildest aberrations, obeys a law which is not less appreciable than those in accordance with which she constructs the fabric of life in both the vegetable and animal creation. It is, indeed, in the strength of convictions thus produced, that the patient student of those laws is enabled to follow with safety and satisfaction the paths in which her footsteps can be traced.

DERMATOLOGICAL NOTES.

BY

ROBERT B. MORISON, M.D.,
Baltimore.ELEPHANTIASIS OF THE FOREARM.—PRURIGO.—DERMATITIS VENE-
NATA.—ERYTHEMA URTICANS.—UNNA'S PREPARATIONS.

IN the Dermatological Notes of the May number, Dr. Fox relates a case of "Elephantiasis of the Forearm and Hand." Such cases are rare, but Dr. F.'s case is not the first one reported in this country. In the *Maryland Medical Journal*, Feb. 21, 1885, will be found the history of a case of E. Arabum of the left forearm and hand which came under my treatment more than a year ago. A brief outline of the case may be worth reprinting.

Mr. —, æt. 50, married, a man of the most generous habits of life, who confessed to a chancre dating ten years back, showed me his left hand. It was puffy, the fingers and back of the hand having a flabby, doughy appearance, evidently the result of previous inflammation. The arm above the wrist, and half-way up to the elbow, was more tensely swollen than the hand. No hard knots or swollen glands could be felt in the skin, but the glandulæ cubitales, as well as the glandulæ axillares, were decidedly enlarged. Both palms were sprinkled over with large and small, round, flattened, brownish-red spots which were evidently specific in character. There was no difficulty in making a diagnosis of psoriasis palmaris syphilitica.

Many years ago, the patient was shipwrecked on a rocky coast, was left for many hours in the water clinging to ropes and rocks, and was rescued with his hands and feet frost-bitten. Since this unlucky accident, these members have been subject to repeated attacks of eczema (?), which would disappear, leaving only the spots upon the palms. The left hand and arm have been subject to recurrent erysipelas, and after each attack the chronic swelling of the limb was slightly more pronounced. A diagnosis of E. Arabum was made, but, contrary to what the patient had been told, its etiology was explained to be syphilis and not frost-bite. He was put upon hypodermic injections of Liebreich's one-per-cent solution of hydrargyrum formamidatum, fifteen minims once a day, for twenty days. At the end of this series of injections, the psoriasis had entirely disappeared. The hands then presented a normal appearance, as far as any frost-bite was concerned, and the œdema of the arm and back of the left hand had decreased one-half. Subsequently I watched the patient through an acute attack of erysipelas of the left arm, similar, he

said, to all previous ones, excepting that it was more severe than usual. He is now attending to his accustomed duties, but his left hand and arm are noticeably larger than the other, and while a moderate abstinence from strong drink—total abstinence (from long indulgence) being out of the question—has put him in better health, yet the *locus minoris resistentiæ* still remains awaiting an exciting cause for just such another attack to increase it.

Prurigo.

After having made a special study of prurigo, both macroscopically and microscopically, in Vienna and Prague (vide *American Journal Medical Sciences*, October, 1883), it was with a great deal of interest that I returned to America, thinking to investigate why the disease was so seldom reported in this country. I had been told on the other side—and it is hinted at in various German authors, *e. g.*, Auspitz, Kaposi, Pick, et al.—that it was probably due to the fact that the disease was not recognized in America. So I have been hunting for two years like Diogenes among the patients of a large clinic for an honest case of prurigo. In all this time I have only seen one case of prurigo simplex. It was that of a young man, *æt.* 23, born of German parents in this country, who never remembered the time when he did not have to scratch himself, night and day, upon his legs, arms, and abdomen. The skin of the extensor surfaces of the arms and legs, as well as that of the abdomen, was parchment-like, dirty-brown in color, slightly excoriated in places, with many isolated small papules scattered about, which were more perceptible to the touch than to sight. The skin felt, when the fingers were passed over it, as if a fine nutmeg grater had been placed underneath it. The glands of the groins, as well as in other places, were enlarged. The diagnosis seemed to admit of no doubt from the situation of the disease, the usual prurigo history, and its general appearance. The man in other respects was perfectly healthy and well developed. The disease worried him more because his fellow-workmen ridiculed his scratching than because the act of scratching was necessary. After coming twice to the dispensary he appeared no more. My assistant, Dr. Keyser, kindly hunted him up, and he was to have been presented to a medical society, but when the time came, he failed us.

Dermatitis Venenata.

I should like to call the attention of dermatologists, especially at this season of the year, to the results obtained in this class of diseases from the use of Prof. Pick's 5% salicylic acid gelatin. The relief to the burning and itching has been almost immediate, and the disease, in all the cases upon which it was tried last year, disappeared after a few days' applica-

tion. It would be interesting to hear the experience of others after trying this remedy upon such cases.

Erythema Urticans.

The dermatologist is not often asked to attend a so-called "urgency" case. The following is an exception, however. Some time ago, a physician drove me hurriedly to see a man who, for the better part of two nights and days, had been walking his room with nothing on but his shirt. So great was the ever increasing itching on his legs he could not keep still, and it was with the greatest possible effort that he kept from tearing the skin from them.

I found upon them, extending from the junction of the legs with the abdomen nearly to the knees and half-way round the inside of the thighs, two very red, blotchy-looking spots with no papules, vesicles, or pustules. The line of demarcation was distinct and in some parts of it was slightly raised. The patient said it had commenced in smaller spots separated from each other, but which had quickly spread until they covered the spaces already described. Eczema of any form was excluded, and I had evidently to do with an aggravated case of urticaria, for which I could think of no better name than the one given above.

It is difficult to imagine the utter demoralization of this poor fellow. He had only found relief from hypodermic injections of morphia. Having taken with me a piece of Pick's 5% salicylic acid gelatin, it was melted in a saucer over hot water and applied with a brush over the whole surface of the affected parts. A small amount of glycerin was rubbed over it when the gelatin had sufficiently hardened. The relief was immediate. The patient slept well during the night and was in his office the next day. The application inconvenienced him slightly, as the gelatin gave him a feeling of contraction upon his legs, but it was nevertheless continued for two days and nights, by which time the irritation had so much subsided that it was discontinued. He has had several similar attacks during the last year, but he is never without his gelatin which he now mixes and spreads for himself, and he has so far been able to control a fresh attack as soon as it appears. An interesting point in the etiology of this case is that the patient finds, if he indulges in the good things of this world to any extent, especially if they be moistened with several drinks of whiskey, he is almost sure to have an attack. He thinks, however, it is the drink and not the food which brings it on, for he has noticed the same result after taking two or three drinks of whiskey without any food. He certainly has had greater immunity from attacks since giving it up.

Prof. Unna's Preparations.

It is surprising that Unna's preparations are not better known in this country.

They have proved themselves in my practice to be useful in a high degree, and I know at present nothing which takes their place. Skin therapeutics has for so long a time consisted of local applications, uncomfortable to the patient, unclean to the clothes, and unsatisfactory to the physician, that any improvement on the old-style treatment should be received with favor. Unna's plasters are simple, clean, comfortable, and efficacious. Their expense has been the only drawback to their introduction into America; our duties raising their first cost beyond the pockets of the masses. This defect will, I hope, however, soon be remedied by their manufacture in this country, and they will then be fully appreciated. Histories of several cases in which they have been used by me can be found in a recent number of the *Deutsche Medicinische Wochenschrift* (Berlin), and *The Medical News* (Philadelphia).

DOUBLE GUMMA OF IRIS, AND ITS EARLY MANIFESTATION (WITH ILLUSTRATION).

BY

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THE notes of the following case of double gumma of the iris were kindly prepared by Dr. Andrew Manning, House Surgeon of the Ophthalmic Division of Charity Hospital. They are of interest, first, on account of the comparative rarity of biniridal gummata; and secondly, on account of their early manifestation, viz., five months after the appearance of the chancre.

J. M., male, aged 23 years; single, laborer, born in the United States, was admitted to ward 13 (Venereal Division), March 6, 1885, with a pustular syphilide attended with crusts, thickly covering the face, arms, and legs, very slightly appearing on the trunk. Initial lesion developed on the foreskin five months before, and thirteen days after vicious connection. Patient at the above date had become so much emaciated as to have weighed about one hundred pounds. He was admitted to the eye-ward late in April, the affection of the eye dating from about April 15. On admission, both eyes presented the usual symptoms of syphilitic inflammation of the iris, viz., lachrymation, photophobia, pinkish zone of

injection around the cornea, opaque anterior chamber, muddy and nodular anterior surface of iris; both eyes and brows were exceedingly painful. Gumma of right iris springs from its lower limb, completely fills the corresponding area of the anterior chamber, and lies in contact with the posterior surface of the cornea; its breadth at base measures one-eighth of an inch. It preceded the development of the left gumma by two days. The latter growth is situated on the outer and upper segment of iris, and invades the pupillary field more than the right one. Under



atropine, the left pupil dilates in the shape of a kidney placed in a vertical position, while the dilatation of the right pupil is but little interfered with. Vision of the right eye is noted "good," while the left eye counts fingers at only five feet.

Patient was treated with a formula of mercurial biniodide gr. $\frac{1}{32}$; potassium iodide, gr. v.; and compound syrup of sarsaparilla, three times a day; locally with atropine solution, gr. iv. ad $\frac{5}{16}$ i., and a collyrium of boracic acid in saturated solution (about four per centum). In addition, patient received a warm bath every second day. Under this treatment, the eruption has already materially faded away, the inflammatory symptoms have abated, and the gummata are being rapidly absorbed. At this date, one of the growths has nearly disappeared, the patient having been but one month under specific treatment.

NEW YORK, May 13, 1885.

VERATRIN IN PRURITUS.—In pruritus occurring about the time of the menopause, Chéron (*Gaz. des Sciences Méd.*, Sept. 27, 1884) recommends the use of veratrin, internally and externally, giving from two to six pills daily, each containing $\frac{1}{20}$ grain. Externally he uses an ointment containing from two to three grains of veratrin to the ounce of simple ointment.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

155TH REGULAR MEETING, MAY 26, 1885.

ANNUAL MEETING.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. BULKLEY presented a case of

LUPUS VULGARIS.

Jennie S., aged 13 years; Hungarian. The eruption first made its appearance three years ago. Now there are characteristic pulpy and tubercular patches of lupus situated on the ears, cheeks, chin, neck, both arms, and buttocks. In some places there is loss of tissue.

The case was shown because of the multiplicity of the separate lesions, there being at least twenty, and also because of their symmetrical arrangement. In many respects, there were points of resemblance to scrofuloderma.

Dr. Bulkley wished to know if any of the members had observed a case of lupus in which there were so many scattered lesions. He had never before seen a case in which there were more than half a dozen isolated patches.

DR. PIFFARD said that he had seen a case of lupus erythematosus in which he recorded about thirty or forty separate lesions as being present.

DR. FOX spoke of some cases of lupus vulgaris that had been presented before the Society, where the hands were affected, and in whom there were many isolated patches. In the cases referred to, it was difficult to distinguish between lupus and scrofuloderma. He had, however, never seen a well-marked case in which the patches were so numerous as in the one shown to-night.

DR. BULKLEY then showed a case of

PITYRIASIS ROSEA (PITYRIASIS MACULATA ET CIRCINATA).

Maggie H., single; 22 years old. Hat trimmer. Her general health has never been very good, being subject to attacks of dizziness and suffering from dyspnoea upon exertion, as well as palpitation at times. Bowels inclined to be constipated. Menses very irregular. There is a tendency to varicosity of the veins.

About three weeks ago, she had intense pruritus of the chest which lasted several hours, when an eruption was discovered, consisting of several bright-red spots, each the size of a ten-cent piece, scattered over the chest. The lesion spread rapidly over the breasts and into the axillæ, and has been gradually extending since.

The eruption now covers a large area, reaching above nearly to the clavicles, covering the breasts, and extending below to the ensiform cartilage, and laterally nearly to the hips. It also extends on each side into the axillæ, where it is most deeply colored; the scapular region is also affected. There is no eruption in the interscapular space, nor in the upper or lower extremities. When the eruption first made its appearance, it was of a bright-red hue. Now, in front and behind, it is a pale, dingy red or yellowish color.

The lesion is composed of separate centres of inflammation, varying in size from a pin's point up to one or one and a half inches in diameter. The circumference of each separate lesion is irregular in outline, the margins being distinct,

except where the patches have coalesced, which is of frequent occurrence. The centre of each of the patches is of a dull whitish yellow, less vivid and depressed as compared with the circumferences. There is, or has been, more or less scaling over each patch. The scales are thickest at the middle, are not easily removed, and at present are most marked about the axillary regions. When a scale is removed, several slight cicatrices remain. Besides the circinate spots, papules and macules are also present. The severe irritation has been confined mostly to the axillary regions.

The patient was sleeping alone when the eruption appeared. Immediately after its appearance she slept with an aunt, who developed a slight itchy eruption on the chest; it remained but a few days, and differed from that seen in the patient.

DR. FOX believed the case to be an excellent example of that rare disease—pityriasis maculata et circinata. He thought many cases of seborrhoea sicca had been described under the name of this disease. He said that the lesion bore many points of resemblance to erythema multiforme, especially in the multiplicity of the lesions.

DR. ROBINSON had seen three cases, one of which was doubtful, because of the marked seborrhoea of the scalp and sternum. Another of the cases was scallier and covered a greater area than the case under consideration. The lesion disappeared in about three months, the treatment being applications of green soap.

DR. BULKLEY remembered having seen two or three cases. One was a most superb case, and occurred in an attendant on a Turkish bath, and disappeared in six weeks under treatment. In another patient, the eruption remained a long time, and finally disappeared slowly.

DR. FOX mentioned the case of a lady who had pityriasis rosea, occupying the trunk and upper and lower extremities. Local remedies were used for three or four weeks with no apparent effect, when quinine was given internally, causing the lesions to disappear in a few days.

DR. BULKLEY presented a

CASE FOR DIAGNOSIS.

He believed it to be one of scrofuloderma papulatum, but at times during the treatment the question occurred to him whether it might not be a case of acne cachecticorum. He would like to have an expression of opinion from the members as to the diagnosis.

Mrs. J. H., 30 years old, married. About seven years ago, she had an ulcer of the throat, which left a scar: this was probably a scrofulodermi. There is no history of syphilis. The teeth are normal. Five years ago, an eruption made its appearance on the back of the neck and shoulders, and has been worse for the past year.

Now on the forehead as far as the hairy scalp, on the cheeks, chin, back and sides of the neck, also slightly on the arms, are maculo-papules of a dull red color, not paling on pressure. These papules are discrete, not very numerous, are covered with a scale, and vary from a pin's head to a pea in size. There is not much tendency to pus formation. The face is slightly oily, and there are a few comedones as well as some acne rosacea. There are many brownish discolorations, and white scars are to be seen where papules formerly existed. Many of the papules have had their summits scratched off. Some of the papules have remained at least six months before disappearing.

DR. BULKLEY next presented a case of

SCROFULODERMA PUSTULOSUM.

A. McC., 36 years old, liquor dealer, denies ever having had venereal disease. He was married when twenty-two years of age, and is the father of four chil-

dren, viz., a girl, 13 years; a boy, 12; a child who was killed accidentally, and a boy, 9. All of his children are healthy, and have had no skin lesions. His wife is healthy, has had no miscarriages, and no eruption. His sister is living and in good health. His father died at 63, and his mother aged 55. They were both free from eruption.

Ten years ago, the patient first noticed an eruption on the back of the fingers, said to resemble that with which he is now affected, and at the time it was supposed that it was occasioned by his occupation as bartender. About six years ago, the lesion first made its appearance on the body. He has never been free from eruption during the past ten years: about five years ago it was at its worst.

At the time, four years ago, when the patient was shown to the Society before, the whole of the body, limbs, hands, feet, neck, chin, and nose, were the seat of an eruption, as follows: On the hands were some deep-seated vesicles; on the palms and some of the fingers were hard masses with surrounding inflammatory areolæ, these masses being about half an inch in diameter. On the back of the elbows were masses of cicatricial tissue and new inflammatory lumps, having very much the appearance seen in syphilis. One hard infiltrated mass was to be seen on the end of the nose. Between the toes of both feet were inflamed masses, resembling mucous patches.

At the time the case was shown before, it was believed to be hydroa, but on further study, Dr. B. has come to the conclusion that it is a scrofuloderma. Now there are several hard lumps and masses on the hands, feet, and extremities. All over the body, buttocks, legs, and arms are marks of scarring, and many cicatrices. In the last four years the eruption has improved, and the patient is in much better health than since the appearance of the lesion.

DR. BULKLEY afterward showed a case of

SCROFULODERMA.

A. H., aged 16 years. When 6 years old, a swelling began on the right side of the neck, and was thought to be mumps. He had been in good health previously, with the exception of having had a slight attack of measles a year before. The mass on the neck broke, and has never healed up since. Six months later he began to have abscesses about the left hip, and was in the Hospital for Ruptured and Crippled for two years.

Since the beginning of the disease, he has had a series of ulcerations about the neck, and on the thighs and hips, the scars of which are present in abundance. There are many open ulcers at present.

DR. FOX believed the first case to be a form of acne, the second and third cases were, in his opinion, scrofulodermata. Referring to the first case, he said that he had seen a case of acne of the back in a woman, in whom there were no signs of eruption elsewhere, and no pustulation, and the patient said that some of the papules had remained six months at least.

DR. SHERWELL would call the first case a lupoid acne. The second and third cases were typical scrofulodermata.

DR. PIFFARD said that there was no question in his mind as to the diagnosis of the second case, viz., scrofuloderma.

DR. BRONSON would call the first case an acne, but differing from an ordinary acne in almost an entire absence of comedones. In this case, there was a certain amount of desquamation of tissue leaving a scar, and constituting the lesion called lupoid acne. In regard to the second case, he had never seen a parallel to it; it was either syphilis or scrofuloderma. His idea was that persons affected with scrofuloderma were profoundly scrofulous, which was not the case in this instance.

DR. ROBINSON believed the first case to be an acne, and said that it reminded him of a case of a woman, 25 years old, who had a similar lesion lasting four years, and during all of that time she did not menstruate. He considered the first case to be a similar one: it was a serous inflammation of the follicles. He did not think that he had ever seen a case where a single lesion lasted six months.

DR. BULKLEY said that he had watched the case closely for nearly a year, and had noted separate lesions lasting for many months. Dr. Elliott had examined a specimen taken from the breast, but with only negative results.

ADULTERATION OF DRUGS.

DR. PIFFARD said that for some time he had found that chrysarobin did not produce the same results as formerly, and that it was comparatively inert.

DR. FOX and other members said that they had the same experience.

DR. BULKLEY then read a paper on

SCROFULODERMA.

An election of officers for the ensuing year was then held, when the following were elected: Dr. W. T. Alexander, President; Dr. E. B. Brounson, Treasurer; and Dr. A. R. Robinson, Geo. H. Fox, and P. A. Morrow, Executive Committee. Under the by-laws, Dr. Robert Campbell remains Secretary until October, when Dr. D. Lewis succeeds to the office.

The Society then adjourned until the fourth Tuesday in September.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

(From our Special Correspondent.)

PROFESSIONAL DERMATITIS, ECZEMA OF SPINNERS AND WEAVERS OF FLAX—NATURE AND PATHOLOGICAL ANATOMY OF ERYTHEMAS. OF POLYMORPHOUS ERYTHEMA IN PARTICULAR—BACILLI OF RHINOSCLEROMA—LUPUS AND TUBERCULOSIS—TREATMENT OF LUPUS.

PROFESSOR LELOIR has observed in his clinic of cutaneous and syphilitic diseases at the Hospital St. Sauveur, of Lille, in 1884 and 1885, a disease of the skin as yet not studied, and peculiar to spinners of flax. This affection is situated upon the hands, and is symmetrical, though the left hand is more often attacked than the right; the internal surface of the thumb, the external and palmar surface of the index, the cubital and palmar border of the hand and of the little finger are the parts most affected. In some cases, the hands and the fingers may be invaded in their entire extent. It is an eczematous dermatitis; it may take on several types; it is sometimes an erythemato-vesicular eczema, more or less confluent; it is sometimes a vesiculo-pustular, sometimes a squamous eczema; it may be a dry lichenoid eczema, with thickening of the derma and fissures of the epidermis, the horny layer of which takes on at certain points a notable development. Pruritus is constant, but quite variable in intensity; there exist certain functional troubles, such as stiffness of the hand and fingers. This affection is peculiar to artisans who work in the flax when wet, and is due to the prolonged

action upon the hands of a hot, viscid water charged with impurities removed from the flax, and containing a quantity of salts of lime much less than that existing in natural water—all conditions which facilitate maceration of the epidermis.

The treatment of this affection, when once developed, consists in the suspension of the work and the application of the means used in ordinary eczema. As to prophylaxis, it will be found of advantage to renew the water as often as possible, and to add to it the lime-salts lacking. The workers should smear their hands with glycerin during their work, and carefully wash them when they have finished.

Nature and Pathological Anatomy of Erythemas, of Polymorphous Erythema in Particular.—The same author has just published very interesting researches upon the nature and pathological anatomy of erythemas and of erythema multiforme in particular. He has studied the diverse stadia of this last affection, as exhibited in fragments of skin obtained from a number of patients during life.

1st. The simple redness is characterized, histologically, by a dilatation of the vessels of the derma, especially at the level of the pars papillaris, and by a slight diapedesis of the white globules.

2d. When the redness is accompanied with a certain degree of thickening of the skin, the dilated vessels are surrounded by veritable muffs of extravasated lymphatic cells, and are engorged with red globules. There is at the same time extravasation of certain red globules, and a quantity of sanguineous serum colored red by the hæmoglobin.

3d. When the process arrives at the formation of papules, there is a considerable exudative hyperæmia of the derma, and even of the hypodermis which remains intact in the preceding forms; in addition, there exists quite frequently a dilatation of the nucleoli of a certain number of the cells of the Malpighian layer, which may sometimes even prevent signs of a cavernous alteration; there is also found a considerable number of migratory cells in the deep layers of the epidermis.

When the erythema takes on a hemorrhagic aspect, the diapedesis of red globules becomes considerable. There may also be seen in the sections a large number of dilated lymphatic spaces, very rarely containing fibrin.

4th. In the papulo-tubercular erythema or erythema tuberosum, the hypodermis is invaded in a much more marked manner: the cells of the connective tissue tend to proliferate, and the exuded liquid often contains fibrin; nevertheless the phenomena of exudative hyperæmia or congestive oedema predominate: the diapedesis of red globules in this last form is generally very abundant.

5th. In the case of bullous or pemphigoid erythema, the histological examination shows: *a*, in a primary degree, when there are not yet phlyctenulæ visible to the eye, the Malpighian body is invaded by a large number of migratory cells, and there exists at certain points of the epidermis the beginning of a cavernous alteration. At the summit of the papillæ, one may observe that the cylindrical cells of the perpendicular layer are detached *en masse* in places corresponding to the extent of about ten cells and constituting thus a sort of minute deep phlyctenule, the cavity of which is filled with a slightly fibrinous exudation containing leucocytes; *b*, in the second stage, a superficial phlyctenule is formed, which is limited above by the horny epidermis with some portions of the stratum lucidum, beneath by the granular zone and the remainder of the stratum lucidum.

The liquid of the bulla contains only a few traces of fibrin and occasional leucocytes. Prof. Leloir then enters into some very interesting pathogenic considerations upon the mode of production of these lesions and the purulent transformation of the phlyctenulæ. Our space forbids us entering into all the details. The conclusion of the author is that, until we are more amply informed, we must still consider multiform erythema as an angioneurosis, the cause of which may be very diverse and multiplied.

Bacilli of Rhinoscleroma.—MM. Cornil and Alverez have submitted to the Academy of Medicine of Paris, March 31, 1885, a most important communication upon Rhinoscleroma. This rare cutaneous affection, which consists of a thickening under the form of plaques and tumors of the nasal septum, the upper lip, the nostrils, the nasal fossæ, sometimes even the lower lip, the pharynx, and the larynx, has been until now especially studied only by Hebra and Kaposi, of Vienna. The patients upon whom Prof. Cornil made his investigations were from Central America. In the first examination, made some two years ago, Prof. Cornil did not observe the parasites of rhinoscleroma, although Frisch, Pellizari, Chiari, and other histologists had demonstrated their existence. A modification in his technique enabled the French observer to discover them; he has since found them in all his examinations and gives the following description: they consist of short rods from $2\frac{1}{2}$ to 3 millimetres in length, and from 4 to 5 tenths of a millimetre in width. This rod presents granules highly colored which resemble spores; the border of the rod slightly exceeds the granules. In coloring the sections for forty-eight hours in a $2\frac{1}{2}$ per cent solution of violet C. B. and in decolorizing them for forty-eight hours in absolute alcohol, the microbes are observed "presenting quite regular ovoid forms, the periphery of which is formed by a transparent hyaline substance, lightly colored in blue violet, and containing the rod encapsuled. At the centre of this capsule is found the rod which is sometimes homogeneous and smooth and strongly colored, sometimes in the form of two, three, or four round or ovoid granules likewise quite pronounced in color. Around the rod there is always a clear line. Many of the encapsuled rods are free in the tissue of rhinoscleroma, between the fibrilla of the pars reticularis, around the large cells, and in the lymphatic vessels, both in the superficial and deep portion of the derma."

According to these researches, it is evident that rhinoscleroma should be classed among the parasitic affections, producing tumors, like tubercular leprosy, perhaps like actinomycosis. Still it is well to not be too hasty in generalizing: it is to be hoped that cultures and inoculations will soon elucidate all the facts so important from a clinical, a therapeutical, and especially a prophylactic point of view.

Lupus Tuberculosis, Treatment of Lupus.—I have endeavored to keep the readers of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES posted in regard to the numerous works published in France for some time past upon the nature of lupus. They are doubtless familiar with the celebrated discussion which took place at the Congress of Copenhagen, and it is quite useless for me to give an analysis of the interesting communications of Prof. Leloir and Dr. Barthélemy. Prof. Besnier has recently broached this question anew with his recognized ability and great authority. This eminent author has, by his lectures, his writings, his clinical researches, and the numerous works which he has inspired, contributed, more than all others, to the elucidation of the relations between lupus and tuberculosis. Profoundly con-

vinced of the tuberculous nature of lupus, M. Besnier has since 1880 taught that lupus is always a scrofuloderma. He has since elaborated his opinions and published his new method of treatment by igneous scarifications. (V. JOURNAL CUTANEOUS AND VENEREAL DISEASES, March, 1884, p. 84.)

In a new communication appearing in the *Annales de Dermatologie et de Syphiligraphie*, Jan., 1885, he reviews the progress which his opinion has made in this brief period, and he endeavors to convert to his view certain opponents who remain, by discussing with the greatest precision the points in litigation. These points are the following. 1st. Nosographical unity of lupus. 2d. Nosological unity. 3d. Relations of lupus with tuberculosis. 4th. Present condition of the therapeutics of lupus.

The nosographical unity of lupus is regarded as indisputable by M. Besnier; perhaps there may be certain forms of syphilis, of leprosy, or of scleroderma which are difficult at first to diagnosticate from lupus; but according to him the existence of a syphilitic lupus should not be admitted. The lupoid lesion is either lupus or syphilis, acquired or hereditary; there is no mixed variety. It sometimes seems that hereditary syphilis may be in certain cases a predisposing cause to the development of cutaneous lesions identical in aspect with lupus—lesions which in some instances are cured by anti-syphilitic treatment. We have often heard our distinguished Prof. Fournier declare that one should divide the profound dermatoses, formerly described under the name of lupus, into two categories; *a*, syphilides, most often hereditary; *b*, tuberculosis.

M. Besnier also remarks that there are certain marked or irregular forms of lupus erythematosus of the face and extremities which might easily be confounded with certain varieties of erosive or atrophic acne, and inversely. In every case, says he, these difficulties depend upon the imperfection of our knowledge and they do not in any manner imply the fundamental reality of a radical dissimilarity between several distinct diseases which might be confounded with that which at the present time it is found convenient to denominate lupus. 2d and 3d. The nosological unity of lupus is at present demonstrated according to M. Besnier: "The different lupuses are only species, forms, varieties of a single and unique pathological genus," "the clinic, histology, and experimentation have proven in the most irrefutable manner that they are only different aspects of cutaneous tuberculosis."

The dissimilarity which exists between lupus of the skin and mucous membranes on the one hand, and lesions of the same part, hitherto termed tubercular, on the other—a dissimilarity most marked and striking—does not constitute for him an argument in favor of the non-identity of lupus and tuberculosis, for "just as the dermatopathies of secondary syphilis differ from those of tertiary syphilis, so primary tuberculosis of the skin (lupus) has not the characters of infectious or tertiary tuberculosis, which alone manifests itself upon the skin or mucous membranes by granulations or typical ulcerations termed tubercular. Of these two lesions, the one is an external, local lesion, evolving for a long time locally upon a non-infected patient, the other is a manifestation of an accomplished general infection." 4th. Dr. Besnier is always faithful in principle to the general treatment of lupus by the method of scarifications and igneous canterizations with the galvanocautery—a method which I have described in one of my previous letters; but he has quite recently experimented in his service with another procedure which has given quite good results in cases of very old and extensive lupus with mutilation. It consists in painting the lupus surfaces with a piece of char-

pie dipped in a maximum solution of pyrogallic acid in ether, or in spraying them with this solution. The diseased surfaces become instantly covered with a white and adherent layer of pyrogallic acid: this layer is then covered with a protective coating of traumaticine. The next few days it produces an irritation analogous to that of a strong vesicatory: but this irritation is limited almost exclusively to the diseased tissues. This is repeated until the complete disappearance of every active lupic element; the consecutive cicatrix is smooth. This method, which is derived from that of Schwimmer, is especially suited for timid patients and in cases of common tubercular lupus; it does not succeed so well in lupus erythematosus, for which the interstitial electro-cauterization is, according to M. Besnier, *the therapeutic method par excellence*.

In terminating this analysis, I regret to add that the ideas just enunciated are far from being admitted by all French dermatologists, by Dr. Vidal in particular. He does not believe in the tuberculous nature of the typical lupus of Willan, of sclerous lupus, and still less of lupus erythematosus. He continues to treat the different varieties of lupus by his method of quadrillated linear scarifications—a method which he modifies according to the indications of different cases and which gives him most excellent local results, without in any way interfering with the general health of his patients.

DR. L. BROCO.

PARIS, May 15, 1885.

Selections.

ODORS OF THE SKIN AND ITS APPENDAGES.

THE perspiration and the various cutaneous secretions impart a peculiar odor to every human being, as well as to each of the inferior species. This physical characteristic, of which, in general, we are hardly aware, is very acutely perceived by those persons in whom the olfactory sense is exceptionally developed. It is well known that many savages, as Indians, negroes, etc., can smell each other at long distances, just as a hound follows up his master by the scent. Individual instances of a similar character, but much more extraordinary, are not unknown in civilized society. Thus, Cadet de Gassicourt, in the *Dictionnaire des Sc. Méd.*, speaks of a young lady who could distinguish men from women simply by their odors, and who could not endure the smell of her bedclothes after any one else had handled them. In the *Journal des Savants* for 1684, we read of a Hungarian monk who was able to decide in the same way upon the chastity of females. The thing is not so very wonderful; we ourselves are acquainted with a physician who makes a specialty of diseases of women, and whose nose informs him with unfailing accuracy whenever a patient is menstruating. The odor of the skin is rarely a pleasant one. Alexander the Great, according to Plutarch, exhaled the perfume of violets when he perspired, and in modern times, Malherbe, Cujas, and Haller are said to have diffused an agreeable odor of musk. In ordinary individuals, the cutaneous odor is sulphurous and somewhat repulsive. Old Ambrose Paré observes that this is especially noticeable in the red-haired and freckled. Dark-complexioned persons smell of prussic acid; blonds, much more feebly, of musk. Fat persons are more odorous

than lean ones; the former frequently have an oily smell, due to an excessive formation of fatty acids in the sebaceous secretion.

Age exerts a considerable influence on the cutaneous odor. Nursing infants have a peculiar sourish smell, caused by the butyric acid in their milk. Bottled children smell of strong butter, cow's milk being so much richer than woman's in the oily principle. After weaning, a baby's odor becomes less decided, and, it is said, more agreeable. The human male, at the period of puberty, exhales a characteristic odor which, though less pronounced, is similar to that of an animal in heat. This odor, which is one of the leading symptoms of what Borden calls the *seminal fever*, is more strongly marked in those who are continent. It is probably caused by the absorption of the spermatic fluid into the circulation and the elimination of its odorous principles through the skin. At all events, it is certain that it disappears as soon as the reproductive organs become enfeebled. In old age the skin exhales an odor which has been compared (without any metaphorical intention) to that of *dry leaves*. It is possible, therefore, to tell, by the sense of smell alone, if not the exact age of a person, at least the period of life at which he has arrived.

The influence of race upon the cutaneous odor, though perhaps less familiar, is quite as indisputable. The inhabitants of southern latitudes do not smell like those of the north. Their cutaneous functions are more actively performed. "The human flower," to use an expression of Goethe's, like the products of vegetation, is more highly perfumed in warm climates. This is especially evident in negroes, whose rank, ammoniacal odor, unmitigated by cleanliness, is attributed by Pruner-Bey to a volatile oil set free by their sebaceous follicles.

The nervous system has a very decided action upon the cutaneous odor, which quite frequently is heightened or modified by mental excitement, depressing passions, and neurotic disease. Gambrini has recorded the case of a young man who, having been crossed in love, became violently jealous, after which his whole body exhaled a fetid, sickening, and very tenacious odor. Dr. Hammond, of New York (*Med. Rec.*, July 21, 1877), speaks of a hypochondriac whose skin diffused the fragrance of violets; of a hysterical female who smelt of pineapple during her paroxysms, and another who perspired on the left half only of her chest, whence she exhaled an odor like that of the iris; her sweat, when analyzed, was found to contain a butyric ether. In cases of localized perspiration, these curious osphresiological anomalies are not at all uncommon. Schmitt knew a man who labored under a hyperidrosis that affected his hands only, and smelt like sulphur. Orteschi met with a young girl who exhaled, without any possibility of fraud, a strong odor of vanilla from the commissures of her fingers. Barbier mentions the case of a captain of infantry, the upper half of whose body was subject to an offensive perspiration which resisted all treatment, and finally obliged him to resign his commission. All these are examples of disordered innervation. Thus, as Hammond remarks, we perceive that the phrase "odor of sanctity" is not a mere figure of speech; it embodies the idea of a *holy neurosis*, which imparts to the skin a perfume more or less agreeable—at least during the actual access of the devotional ecstatic paroxysm.

The foregoing facts are curious merely. We now come to others which are of practical importance. In lethargy (hardly ever witnessed except in hysteric subjects), the very perspiration has a cadaverous odor, thus adding another touch to the perfect picture of death already presented by this condition. This odor, there can be no doubt, has aided in the production of some lamentable mistakes.

The smell given forth from the skin in mental disorders is thus described by Fèvre, in his work on the alterations in the cutaneous system arising from insanity (Paris, 1876): "The odor of the sweat in lunatics is of a very peculiar nature. Fetid and penetrating, it resembles the emanations from hands kept constantly closed, and is allied to those of the yellow deer and of mice. It is met with more especially in subjects of general paralysis and confirmed dementia. It impreguates the garments, bedclothes, and furniture of the patient, and even pervades his apartment, and is exceedingly tenacious, *despite the utmost attention to cleanliness*. This odor is so characteristic that Burrows declares *he would not hesitate, even in the absence of other evidence, to pronounce any person insane in whom he might perceive it*." Another English alienist, Dr. Knight, goes still further, claiming that the absence of this symptom enables him to discover when insanity is feigned.

The affection to which Hebra has given the name of *bromidrosis* consists in an offensive odor of the skin resulting from an abnormal condition of the *materia perspiratoria*, without any increase in the quantity exhaled. It may be confined to particular portions of the body. *Bromidrosis pedum*, for example, is quite a common disorder. Even kings have not always been exempt from this odious infirmity—witness some of the stories told about "Le Roi Soleil," Henry of Navarre, whose neighborhood was almost insufferable to his courtiers, and whose very mistress reproached him with smelling "like a carrion."

The inguino-vulvar and inguino-scrotal perspirations possess an aromatic odor closely akin to that of the genital region in either sex.

The axillary sweat owes its peculiar redolence to the alkaline caproates; also, to certain volatile and odoriferous free acids; for, as Robin observes, none of these bodily odors is caused by any single element, but always arises from a combination.

Hyperidrosis of the axillæ is not uncommon. It is especially apt to occur when the body is unclothed, and, in women, during the catamenia, at which period it diffuses an aromatic odor of acids or of chloroform.

Localized sweats, almost always of tropho-neurotic origin, have usually a strong smell. This is probably due to maceration of the epidermis in the effused fluid—epithelial desquamation being also of frequent occurrence in all such nervous conditions. Weir Mitchell has observed that in lesions of the nerves the corresponding cutaneous region exhales an odor like that of stagnant water. This, we believe, is owing to a disturbance of the epithelial nutrition, rather than to any actual alteration in the sweat.

The ingesta, whether nutritive or medicinal, readily eliminate their odorous principles through the skin, and thus exert an influence upon the cutaneous odor. Garlic, alcohol, coffee, truffles, valerian, musk, turpentine, tar, sulphur and its alkalies, the fetid gum-resins, ethers, angelica, benzoic acid, iodine, and the iodides, phosphorus, etc., transmit to the integument their respective odors, more or less modified, according to the functional activity and also to particular idiosyncrasies. Copaiba diffuses its tell-tale fragrance in the same way. Sulphate of potassa is decomposed within the organism, and imparts to the sweat a hydro-sulphurous odor. Phosphate of zinc causes garlicky-smelling perspiration, etc.

In acute alcoholism the perspiration often has the odor of aldehyde, a peculiarity of value in diagnosis, as serving to distinguish the lethargic form of intoxication from apoplexy. Finally, I have noticed in the case of a lady who was

taking Fowler's solution of arsenic, the occurrence of very offensive axillary sweats, which ceased when the medicine, at her earnest request, was discontinued.

Sufferers from incontinence of urine smell of this fluid, or else like mice. Similarly, constipation gives rise to a fecal odor of the skin, which, when perceived by the subjects themselves, frequently aids in producing hypochondria, a condition to which this class of patients is always liable.

The "hospital odor" is essentially variable in character, being chiefly caused by an aggregation of cutaneous smells. Hence it is that the wards devoted to women and children are perfumed with butyric acid, while those of the men proclaim the presence of alkalies and ammonia.

In gout, the cutaneous secretions exhale a peculiar odor, likened by Sydenham to that of whey. Icteric patients smell of musk; syphilitics of honey; scrofula is marked by the odor of sour beer; intermittent fever by that of fresh bread. In diabetes, when there is perspiration, it smells like hay, or rather, according to one authority, like acetone; Bouchardt thinks that the odor in this disease is intermediate between that of aldehyde and of acetone, being due to a mixture, in different proportions, of these two bodies.

In cholera, Drasch and Porker have noticed an ammoniacal odor which they attribute to an elimination of urates in the sebaceous secretion.

In women recently confined and during the milk fever, the perspiration, especially at night, has a sour smell. Under the influence of pestilential maladies, the skin, according to Biemerbrock, exhales a peculiarly agreeable odor. Strange to say, this old-time observation has been confirmed by Döppner, who says that all the plague-patients at Vetlianka diffused an odor resembling that of honey.

In febrile conditions generally, the outer integument develops a sort of *moist* odor which is quite indescribable. Contagious fevers, as also the virulent disorders (rabies, glanders, and malignant pustule), are accompanied by a putrid smell.

In dysentery, the sweat reveals an unmistakable odor of the dejecta, as is strikingly evident on entering a hospital ward devoted to this complaint.

In typhoid fever, the cutaneous odor is remarkable. Béhier calls it an *odor of blood*, and Fred. Berard says that it will attract the flies even before life has left the body. However slightly manifested, it is always the immediate forerunner of death. Dr. Althaus reports that Skoda has never been misled by this indication, and Crompton, of Birmingham, also mentions it as an important clinical symptom. This effluvium of the moribund is quite unlike the death-smell itself, which again is also *sui generis*, and not at all allied to the odor of putridity.

Classical authorities are quite at sea about this typhoid emanation. It is truly what Béhier describes it—an odor of blood. The *mouse-like* smell belongs more properly to typhus. It is consequently absurd to maintain, as Hjaltelin does, that these two fevers are marked by the same odors, and to infer from thence their mutual analogy.

A putrid odor, of variable character, is observed in pyo-septicæmia, scurvy, bilious remittent fever, and the watery cachexia, or Egyptian chlorosis, of Griesinger. Recently established theories concerning the alterations caused by these disorders in the cutaneous secretions, afford an explanation of this symptom. As for the ammoniacal odor which has been remarked in the course of cerebral affections, we think, with Lallemand, that it is often caused by an incessant urinary overflow.

In acute articular rheumatism, the sweat becomes more acid in proportion to its abundance, especially about the swollen joints. Its odor becomes markedly sour and penetrating. Some authors attribute these qualities to an excess of lactic acid, but are they ignorant that this latter is itself without smell? The odor in question is clearly due to the presence of acetic and formic fatty acids, whether these exist originally in the rheumatic sweats, or result from a transformation of the cutaneous secretions in their entirety, and not at all (as Ernest Besnier contends) to the abundance of the sweats, and their retention and decomposition, favored by a high temperature, by the immobility of the patient, and by the saturation of his long-worn garments. In refutation of this latter idea, it is sufficient to point to the profuse perspirations in phthisis, which never smell like those of rheumatism; neither can the rheumatic odor be prevented by frequent changes of linen or by the utmost attention to cleanliness.

In miliary sweats, the odor, at once acrid and nauseating, has been likened by epidermological writers to that of vinegar, rancid oil, mouldiness, and rotten straw; this last comparison being, in our opinion, the most accurate. This variety of perspiration ferments very easily, and hence has been described as smelling like "spoiled vinegar."

We now come to the cutaneous odors connected with the eruptive fevers. Hebra quotes Heim, of Berlin, as maintaining that each of these complaints has its peculiar odor, recognizable by the experienced physician. In measles, we have the smell of feathers freshly plucked; in scarlatina, that of bread hot from the oven; in small-pox, that of the yellow deer, or of a menagerie. These odors, in Hebra's opinion, "are not pronounced enough to be regarded as characteristic," a criticism which we do not consider altogether just. Some of Heim's picturesque comparisons may perhaps be drawn from his imagination, but there is certainly a marked difference between the cutaneous odor in the suppurative stage of variola and that in a case of measles.

Skin diseases of whatever kind, when seated on the genital organs or the anus, between the toes or in the axillæ, exhale the odors peculiar to their respective localities, but with a still higher degree of fetidity. Scrofulous sores, lymphatic dermatoses, eczema, impetigo, *croûtes de gourmes*, etc., have a feebly acid or mouldy smell. Sebaceous acne exhales a nauseous, rancid odor, which is *sui generis*. Eczema *pilaris* has a repulsive fetidity, probably due to retention of extravasated products. Rupia is not only of hideous aspect, owing to its scabs and purulent exudations, but is prominently characterized by its offensive odor. Pemphigus discharges a serum which normally has an insipid smell. When this changes to gangrenous, it announces the appearance of a malignant septicæmic form of the accompanying fever.

The odors of impetigo, of rupia, etc., are doubtless derived from the decomposition of the muco-purulent secretions in those diseases, and from the maceration of the exfoliated scabs in the altered fluids of the pustulous bullæ.

The hair possesses a normal odor which is peculiar, but scarcely definable. It varies in different races: the hair of the Chinese, as is well known, has a natural smell of musk, which cannot be washed off even with the aid of strong chemicals.

Hairs lose their odor after falling off. Barbers can tell at once, by simply smelling at a lock, whether it was cut from the living head or made up from combings.

In hysteria, and especially in hysterio-epilepsy, the hair takes on, during

the paroxysm, a specific odor which is always the same, and resembles that of ozone.

In *tinea favosa*, the odor of the scalp affords a valuable diagnostic indication well known to all dermatologists. Offensive and nauseating, it has been compared to the smell from a nest of mice, to that of cat's urine, and to marshy effluvia. It grows worse as long as the disease continues, but may be lessened, though never entirely got rid of by attention to cleanliness. It is eminently characteristic of the complaint, and after having been once recognized, can never be mistaken.

This odor is entirely distinct from that of the pseudo-tinea, especially the *tinea granulosa* of Alibert, which is a simple impetigo of the scalp, frequently offensive, but smelling like sour milk, not at all like mice.—E. MONIN, *Sur les Odeurs du Corps Humain*. Prize essay, Paris, 1885. (*Ann. d. l. Soc. de Méd. d'Anvers*.)

THE BACILLI OF SYPHILIS.

THE inquiries to which this article relates having been conducted without reference to the labors of my predecessors in the same department, I deem it unnecessary, on the present occasion, to enter into historical details, which, moreover, would merely be a repetition of what I have already published.

My examinations of syphilitic products have resulted in the discovery of a well-marked micro-organism very closely allied in its morphological relations and mode of staining to the bacilli of lepra and of tubercle, and also occurring, like the latter, in exuberant granulations. It measures, usually, from $\frac{2}{3}$ to $\frac{3}{4}$ mm. in length, by $\frac{1}{4}$ to $\frac{1}{6}$ mm. in diameter, and exhibits an irregularly undulating surface beset with slight indentations. It is also seen to form projecting spines, which appear as clear, oval-shaped, shining spots on the deep-colored bacilli, and are contained, to the number of from two to four, at equal intervals in each of them.

These objects were not found moving freely, but inclosed in cells that were sometimes twice the size of a white blood-corpuscle, roundish, oval, or irregularly polygonal in shape, and frequently containing nuclei in the form of clear spots on their centres or sides. The cells were more abundant on the borders of the infiltration, as also in the apparently healthy tissue immediately adjoining. They were likewise observed in connection with papule in the rete Malpighii, and imbedded in the spinous cells of the latter; also close to a sclerosis within the lumen of a large lymphatic. Being thus endowed, apparently, with the power of active locomotion, it is quite likely that they are migratory cells.

The technical processes by which these microbes were brought into view proved entirely ineffectual in the case of other fungoid parasites. They failed when applied to the products of splenic fever, typhus, glanders, endocarditis ulcerosa, croupous pneumonia, various wound-secretions, acne and itch pustules; also, as was to be expected, in the examination of normal tissues.

So far, sixteen cases of syphilis have been investigated in this way, *i. e.*, prepared sections from two scleroses, one lymphatic gland, three papulous efflorescences, and four products of the gummy stage; also, the secretions from three scleroses and as many moist papulæ. Positive results were obtained in each of these instances—although the number of bacilli detected was mostly inconsiderable, depending, apparently, upon the age of the infiltration and the period of time which had elapsed since the disease was contracted.

In specimens from two *soft chancres*, no microbes whatever were discoverable.

Equal diagnostic importance, I am inclined to think, attaches to the demonstration of the syphilitic bacilli in secretions, as to the presence of the tubercle-bacilli in expectorated matters.

In discharges from secondary lesions, the microbes were remarkably abundant, but their number diminished considerably after a short course of local treatment.

Since, therefore, undoubted syphilitic products of different kinds have always revealed the presence of a single variety of bacilli, distinctly characterized and hence to be regarded as specific; and since, in other contagious diseases, the uniform occurrence of peculiar micro-organisms is justly regarded as indicating their mode of origin, I consider it highly probable that the parasites I have discovered are carriers of the syphilitic virus.

Some of the facts already mentioned are strongly confirmatory of the theory that the syphilitic poison, after its primary deposition, is taken up first of all by the lymphatics, from which it subsequently passes into the general circulation.

The presence of migratory cells containing bacilli in the rete Malpighii agrees with the clinically observed circumstance that syphilitic infiltrations have only to part with their horny epithelial covering in order to become infectious.

Moreover, the detection of precisely similar organisms both in primary and secondary products and in typical gummatous formations, goes to show that these latter are to be regarded as genuine specific affections, and not as the results of a syphilitico-mercurial cachexia.

I cannot conclude without the expression of a hope that future researches, especially in the direction of pure cultivation and inoculation, may succeed in establishing an etiological connection between syphilis and the above-described bacilli, and thereby furnish us with an effective weapon against one of the most lamentable and widespread evils that afflict humanity.—SIGM. LUSTGARTEN, *Wien. Med. Wochenschr.*, No. 17, Apr. 25, 1885.

SYPHILITIC GUMMATA OF THE LARYNX.

SYPHILITIC gummata of the larynx are not so rare as generally supposed; they manifest themselves singly or in a multiple infiltrated form.

The epiglottis, the aryteno-epiglottic fold, the arytenoid cartilages, and the inferior vocal cords constitute their seat of predilection. Tobacco, alcoholic drinks, speaking, and singing are the principal causes which determine the localization of gummata upon the phonating organs. These lesions occur with equal frequency in both sexes.

Gummata are either superficial (gummosus laryngitis, properly so-called) or deep (chondritis, peri-chondritis). We divide gumma into four stages: of formation, of softening, of ulceration, and finally of reparation.

Functional symptoms, and especially signs furnished by the laryngoscope, characterize the disease during these four periods.

The first stage is characterized by hoarseness, by slight pains, and by a redness and small indurations which are revealed by the laryngoscope.

The second stage is characterized by the same signs, and additionally by an engorgement of the cervico-maxillary glands and the development of gummata exhibited by the laryngoscope.

The third stage is characterized by a puffiness of the region of the neck, by

pain, increased on pressure and by deglutition, by hoarseness, raucity of the voice, and aphonia.

The laryngoscope shows an ulceration of the larynx of variable extent; its edges are perpendicular, with a peripheric areola and œdema of the aryteno-epiglottidean region; the ulcerated base is yellowish and covered with a thick, grayish matter.

Finally, the fourth stage is characterized by cicatrices and all the functional signs which accompany them. The diagnosis is quite difficult during the ulcerative stage of the gumma, because the ulceration may be confounded with all other ulcerations of the larynx. Still the antecedents of the patient, the ganglionic engorgement, the localization of the lesion and of the neighboring œdema, the laryngoscopic examination and, if necessary, specific treatment, will elucidate the diagnosis.

Syphilitic gummata are less serious during the first two stages, and by appropriate treatment their resorption may be effected without any unfortunate consequence. Ulcerating gummata are, on the contrary, very grave, not only on account of the immediate functional troubles which they provoke (œdema), but also from the stricture which they may leave as a result.

The treatment differs in no respect from the ordinary treatment of gummata in general. The results obtained by the administration of the syrup of Gibert will be much more satisfactory when this medicament is promptly given. The reparative process may be hastened by cauterizations. The œdema may be combated by cauterizations with chromic acid in solution (25 to 50 per cent) and by scarifications. If these means fail, it may be necessary to have recourse to tracheotomy, which, done promptly, gives good results.

The strictures may be combated by dilatation or by incision (Isambert) and, if necessary, tracheotomy.—DR. GEORGES C. LATOUPHIS, *Th. de Paris*, 1884.

CONTRIBUTION TO THE STUDY OF THE PIGMENTARY SYPHILIDE.

1st. The pigmentary syphilide is a cutaneous dyschromia in which two adjacent surfaces give us, one the perception of hyperchromia, the other the illusion of achromia. The hyperchromia presents itself in the form of islets, circles, or polycircles contiguous to each other and more or less numerous. Isolated or confluent, their dimensions vary from the size of a lentil to that of a twenty-five-cent piece; the hyperchromia occupies the inter-insular spaces. The form is subordinate to the number and dimensions of the hyperchromic spots. The complexity of the phenomenon is admirably expressed by the term "dappled syphilide." But this term is not applicable to the accident either at its beginning or period of decline.

In its full development, the hyperchromic islets are geometrically circular; this geometric aspect is not present in either the initial or retrogressive stage. Its diagnostic value in the pigmentary syphilide is, by this fact, considerably lessened. At this epoch, also, the contrasts of color are not so marked, and the signification of the dyschromia is quite equivocal.

2d. In two-thirds of the cases, the pigmentary syphilide is quite visible, even from a distance; in the other third, it is necessary to search for it.

3d. It often appears shortly after the roseola, at the beginning of the secondary stage.

4th. Its duration is long, it may persist for years, and in certain cases it may continue indefinitely.

5th. It is extremely frequent in young women; it becomes quite rare after the twenty-fifth year; it is much more common in women than in men.

6th. Its seat of predilection is the neck, especially its lateral faces. It is sometimes found on the back of the neck, the shoulder, the region of the pectoralis major, and above the crural arch, rarely upon the extremities, very rarely on the face.

7th. It is not the posthumous expression of an anterior syphilitic eruption. It is a direct manifestation of the syphilitic diathesis.

8th. It does not appear probable that it is due to any alteration whatever of the blood. We are inclined to believe that the nervous system plays a preponderating rôle in its pathogenesis.

9th. Microscopic examination has demonstrated that there are pigmentary granules at the level of the hyperchromic islets. The microscope fails to enlighten us upon the double question: 1st, if there is a pigmentary rarefaction at the surface of these islets: 2d, if there is a pigmentary proliferation at the surface of inter-insular spaces. For, upon the neck, there is not a normal coloration; there are only variable pigmentations. Nevertheless, we think that, at the surface of the islets, there exists a rarefaction, or at least a defect of pigmentary renovation, and at the surface of the inter-insular spaces a compensatory pigmentation is produced.

10th. The dappled syphilide cannot be mistaken for vitiligo or discolored cicatrices. In the great majority of cases, the error may be so easily avoided that it may be considered as a pathognomonic sign of syphilis.

11th. It suffices to have seen a pigmentary syphilide only once in order to recognize it.

12th. The prognosis of the pigmentary syphilide presents no other gravity than that of the disease of which it is an expression.

13th. We are ignorant of any successful treatment of the pigmentary syphilide.—DR. MAIREAU, *Thèse de Paris*, 1884.

ON CERTAIN ALTERATIONS IN THE LYMPHATIC VESSELS IN THE COURSE OF SYPHILIS.

1. THE lymphatic system undergoes an almost constant alteration in the course of syphilis. But while the ganglia are quite often modified, the lymph-vessels, on the contrary, are very rarely so.

2. The lymphopathies exist under many conditions, and may be divided into six clinical forms:

a. In the first place, there is a simple inflammatory lymphangitis consecutive to a specific ulceration, however excited.

b. A lymphopathy may complicate the infecting chancre, and then it bears the same relation to the lymphatic vessels as the adenopathy consecutive to the syphilitic chancre bears to the lymphatic ganglia.

c. There is observed a secondary disseminated lymphopathy, which evolves under the sole influence of the diathesis, without being under the dependence of a local manifestation.

d. In the tertiary stage, certain lymphatics, principally those of the dorsum of the penis, may become sclerosed, and give rise to a special lymphopathy.

e. A cutaneous manifestation of late hereditary syphilis may be complicated with lymphangitis having a special aspect.

f. Finally, in acquired, as in hereditary syphilis, there exist alterations of the

visceral lymphatics. These alterations, carefully studied from an anatomico-pathological point of view, occasion no characteristic clinical symptom which enables one to diagnose them.

3. Clinically, the different lymphopathies are particularly characterized by the existence of hard, mobile, indolent, aphlegmatic cords, situated exactly upon the anatomical course of the lymphatic vessels. For this the first and the sixth forms described are an exception. The first is an inflammatory lesion, and the sixth a visceral lymphopathy.

4. The treatment should be specific and constitutional. Mercurial frictions are injurious in these cases, because they may irritate the skin or inflame or alter the lymphatic vessels which are predisposed to phlegmasies by the fact of the syphilitic diathesis. In grave cases, subcutaneous injections may be employed which, despite their inconveniences, constitute a most energetic therapeutical measure.—DR. PAUL SALLÉ, *Thèse de Paris*, 1884.

PEMPHIGUS ACUTUS CONTAGIOSUS ADULTORUM.

UNDER this name, Dr. Erik Pontoppidan, in *Hospitals-Tidende*, April 1, 1885, describes a disease of which he has seen twenty cases in the course of a year. Kaposi, Lang, Weyl, and Geber, have published descriptions of similar cases, which proved to be *tinea trichophytina*, with tendency to exudation of serum under the upper layers of the epidermis, that are lifted up as large bullæ. But Pontoppidan has never been able to find vegetable parasites in these eruptions. On the other hand, the clinical appearance corresponds entirely with what was first described by Tilbury Fox as contagious impetigo. The process does not extend beyond the deeper layers of the epidermis. The exudation is purely serous, in other words, we have to deal with a bullous formation, a pemphigus. Perhaps the disease is related to the acute contagious pemphigus of infants, in which Riehl recently has found vegetable parasites.

The observed cases presented a rather uniform type. A child or young grown-up person of the lower classes, who neglect personal cleanliness, presents himself with an affection of the face that, at the first glance, appears as a quite considerable skin disease, an old neglected eczema or burn covered with scabs. On a more careful examination, the face, to a greater or smaller extent, is found to be the seat of round, coin-like scabs of different age. Some of them are quite dry, dark-colored by dirt. They are not very adherent, and under them the skin is red, smooth, but otherwise normal. Others, of a younger date, are more fresh, moist, and adherent, and under them is yet found a little serum and a round, red, swollen, but not excoriated surface of skin. Often the spot is surrounded by a kind of collar formed by the remnants of the original blister. Finally, all transitions may be found to the fresh pemphigus vesicles, which may be like the blisters produced by cantharides, but less tense, more flat and fragile, so that they easily burst.

The patient relates that the affection has begun suddenly, a few days since, with the formation of blisters, which soon were transformed to scabs. The general health has not suffered. There has not been much itching. The patient comes mostly because the disease "looks so bad."

If one is sure of his diagnosis, he may confidently give a good prognosis. By any kind of protecting treatment, for instance, salicylic acid paste or zinc oint-

ment, the process will be cured in the course of a week or two. The scabs fall off, and leave red spots, which disappear without any trace.

The observed cases showed a distinct epidemic and contagious origin. They came in small groups about the same time, and in several cases, members of the same family or friends had acquired the disease from one another.

In rare cases, the disease affects other exposed parts of the skin than the face.

SYPHILIS AND TABES DORSALIS

THE figures of which Eulenberg avails himself in discussing the question of the etiological connection between syphilis and tabes dorsalis, refer to 125 cases, retained under his observation during a period of four and a half years. Of this total, 106 were men and 19 women; among the former, a large contingent was furnished by the railway service; only 2 of the women were unmarried. Twenty-eight of the 106 men had been affected by typical sclerosis and secondary symptoms; 11 had only had soft chancre, without constitutional sequelæ; the remaining 67 showed no evidence of ever having suffered from syphilis in any form. That is, infection (reckoning the *ulcus molle* as a variety of syphilis) had occurred in 36.8 per cent of the male patients. Among the women, syphilis could only be ascertained to have existed in a single case; in a few instances it was directly excluded. When the cases in which tabes had been preceded by syphilis were collectively regarded, no one symptom was found belonging to them all which was not also to be met with among the non-syphilitics.

Attention was likewise paid to the other causes of locomotor ataxy, and the influence of heredity was traced in 15 cases; that of exposure to weather in 62, and of such exposure combined with over-fatigue, in 42; of bodily exertion, in 34; of severe emotional disturbance, in 16; of the imagination, in 6; of acute diseases, in 5 cases of importance.

Such being the result of this numerical test, its author can hardly be thought to err in conceding to syphilis in this relation only the rôle of a debilitating agent, or of one predisposing to tabes, a rôle which is also performed by the other etiological factors above cited. He lays considerable stress upon the fact that tabes is not of frequent occurrence among prostitutes, and that a previous syphilitic infection appears to be without significance in its bearings upon the prognosis and therapeutics of the disease.—EULENBERG, *Virchow's Arch.*, Vol. 99 (*Wien. med. Wochens.*).

SYPHILITIC ARTERITIS, ESPECIALLY THE ACUTE FORM.

SYPHILITIC arteritis may affect two different forms, one acute, the other chronic; the latter sometimes terminates in an aneurism.

Syphilitic arteritis may be found in any of the arteries of the body, but it is most often localized in the arteries of the head, the other vessels remaining healthy. It is a circumscribed, often symmetrical arteritis.

It presents two periods in its evolution: 1st, a period of induration, with the preservation of the lumen of the vessel; 2d, a period of obliteration of the artery with all its consequences.

Acute syphilitic arteritis has peculiar characteristics exhibited in its course and the special symptomatology which it produces. It should be studied along with chronic syphilitic arteritis.—DR. BAROUX, *Thèse de Paris*, Nov. 10, 1884.

TREATMENT OF VARICOSE ULCERS BY FREE INCISIONS.

1st. It is in the treatment of very extensive varicose ulcers that the procedure of M. Gay, modified by Dolbeau, has given the best results. It is especially in these cases that this method should be recommended.

2d. This procedure leads to rapid cicatrization. In five cases of varicose ulcers taken at random from the service of B. Onger and treated by this method, the average duration of the treatment was forty-one days.

3d. The cure appears to have been complete. We have observed, whenever it was possible to do so, these patients after their exit from the hospital, and a relapse did not occur.

4th. This method of treatment has given equally good results in the treatment of other varieties of chronic ulcers, and principally in ulcers consecutive to burns of the external integument.—DR. CHEVALIER, *Th. de Paris*, 1884.

HYPERTROPHIC SYPHILITIC CHANCER.

HYPERTROPHIC syphilitic chancre has a prolonged evolution varying from three to seven months and which may on this account be sometimes confounded with canceroid.

It is almost always extra-genital and is situated by preference upon the face.

Its diagnosis, which at first appears difficult, is singularly simplified by the appearance of secondary accidents and the coincidence of ganglionic engorgement.

Its prognosis is, in general, quite benign as a local lesion and this form of chancre does not indicate a greater gravity in the resulting syphilis.—DR. L. ZWETITCH, *Thèse de Paris*, July, 1884.

CERTAIN CONSIDERATIONS UPON GONORRHOEAL ARTHRITIS.

GONORRHOEA is a parasitic and virulent disease. It determines articular manifestations analogous to those which complicate all virulent diseases.

These manifestations present none of the characteristics of true rheumatism: and should not be confounded with this disease. They should be classed as arthrites.

They result from a special intoxication, due to the presence of a microbe in the organism.

The causes capable of modifying the intimate structure of the articulations play an essential rôle in their production.—DR. E. CHOTIER, *Thèse de Paris*, 1884.

Reviews.

THE OLEATES: AN INVESTIGATION INTO THEIR NATURE AND ACTION. By JOHN V. SHOEMAKER, A.M., M.D., Lecturer on Dermatology at the Jefferson Medical College, Philadelphia, etc., etc. Philadelphia: F. A. Davis, 1885.

As is well known, Dr. Shoemaker was chiefly instrumental in introducing this class of preparations to the notice of the profession, and no one is better qualified by practical experience to speak authoritatively concerning their therapeutical value.

The combination of oleic acid with medicinal substances has now been extended to embrace quite a large number of drugs in dermatological use. Not

only do they possess decided advantages in the treatment of many forms of skin affection; but on account of the remarkable penetrating power of oleic acid, they constitute, it is claimed, a superior mode of introducing the drugs into the economy, and thus securing their constitutional effects.

The little volume before us contains a résumé of all that the author has written concerning the oleates and their uses, together with much new matter, embodying the results of his later experience. To those of our readers who wish to learn all about the origin and history, the process of manufacture, the physiological action, and the therapeutic effects of a class of preparations which are destined to grow in favor as their merits become more generally known, we commend this little book.

Received.

Manual of the American Dermatological Association. New York, 1885.

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ETIOLOGY OF LICHEN ÆSTIVUS.—A Texas exchange says there are hot springs in Mexico that cure people of all eruptive diseases. That all depends on what kind of a hot spring the editor is writing about. A hot spring down here in Texas makes pimples, boils, and prickly heat come out all over some of our most respectable citizens. A hot summer is even worse than a hot spring.

Editorial.

CHRYSAROBIN.

AT several recent meetings of the NEW YORK DERMATOLOGICAL SOCIETY, there have been informal discussions concerning chrysarobin (chrysophanic acid), and more especially in relation to its apparent deterioration in strength and activity. The experience of several of the members was given, and no one present contested the prevailing sentiment, that the chrysarobin now obtainable in this market was greatly inferior to the article furnished at the time of its first introduction. In other words, it requires two or three times as much chrysarobin to obtain a given effect as was formerly necessary. A few years ago, an application containing, say, five per cent of chrysarobin would usually produce an active dermatitis, and a prompt therapeutic effect. At present, we cannot obtain the same results from a ten-per-cent application.

The important position occupied by chrysarobin in cutaneous therapeutics at the present day renders any tampering with its quality a matter of serious concern, and with a view of elucidating the question, we are making an effort to ascertain all the facts in the case. To this end we have corresponded with several wholesale and importing druggists, and with others both in this country and abroad. So far as we can learn, most of the chrysarobin sold here comes from Merck, of Darmstadt; and to him, therefore, we must first look for an explanation of the matter in question. We here publicly call his attention to it, and tender him the full use of our columns for any statement he may think fit to make.

In order to ascertain whether the dissatisfaction is purely local (New York) or is more widespread, we respectfully invite our colleagues in other cities, here and abroad, to communicate their experience. Until the entire facts are before us, we suspend judgment.

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DESQUAMATIVE SCARLATINIFORM ERYTHEMA.

BY

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DESQUAMATIVE scarlatiniform erythema is characterized by an initial stage of pronounced fever, similar to that of scarlatina; by an intense redness of the entire cutaneous surface, which subsequently peels off in flakes; and by the occurrence of complete recovery in from three to six weeks. Apparently, the disease is non-contagious. The dermatologists, Besnier and Féréol, by whom this group was first classified, prefixed to its title, as given above, the designation of "relapsing," because, after the subsidence of a primary attack, the eruption occasionally reappears—though in a somewhat milder form—three or four times in succession, or even oftener.

History.—The first clearly described cases of this disorder were those published by Benjamin Gooch,¹ and by John Latham.² No others are to be met with in medical literature down to 1829, when Thomas Newell³ reported a solitary example. Since then the eruptions we are speaking of appear to have been confounded either with pityriasis rubra, or with general exfoliative dermatitis. Thus, Tilbury Fox⁴ relates a very remarkable case of what he calls *an anomalous form of pityriasis rubra*;

¹ "Account of a Singular Separation of the Cuticle." *Philos. Trans.*, 1769, p. 281.

² *Ibid.*, 1770, p. 451-453.

³ "Case of Exfoliation of the Epidermis" (*London Medical Gaz.*, vol. iii., April 4, 1829, p. 976).

⁴ "Skin Diseases," p. 258.

and another well-marked instance is adduced by Percheron, in his thesis, where it is classified, along with those described by Gooch and Latham, as a second form, or pseudo-exanthematous variety, of general exfoliative dermatitis. Henceforward, however, cases of this sort become more abundant. Two are cited in Derrecasaix's thesis¹ in 1876. A highly typical one was communicated by Féréol to the Paris Hospital Society;² and in the discussion which ensued, it was maintained by Besnier, E. Vidal, and Féréol that the disorder in question was a hitherto unrecognized morbid entity differing entirely both from the "herpetide exfoliative" of Bazin (Besnier) and from general exfoliative dermatitis (Vidal); this newly discovered group they would designate as *relapsing desquamative scarlatiniform erythema*, and would place it in the class of pseudo-exanthemata. This distinction was not fully apprehended by succeeding French authors, who sought to identify with desquamative scarlatiniform erythema the cases described in England under the name of pityriasis rubra. Yet we may find in their treatises scattering but unequivocal references to the disease under consideration (Case I., in Bussy's thesis.³ Cases I. and II., in Collard's thesis.⁴ Case I., in Tremblay's thesis.⁵) Chevallier Preston⁶ not long ago described a case which was undoubtedly of this sort. I myself have observed several others—one at the Hôtel Dieu in Paris, reported by my friend and colleague Richardière,⁷ two at the St. Louis Hospital, in the service of Professor Fournier; finally, a very characteristic example in private practice. This inclines me to believe that the affection is not of very rare occurrence, and that it eludes recognition in the great majority of instances.

In Germany, too, it has been described by Vogler de Wetzikon,⁸ under the name of *recidivirendes exanthem*; by Buckardt-Merian⁹ under that of *recidivirendes scharlachähnliches exanthem*; by Daniel Bernonlli¹⁰ under that of *exanthema scarlatinoïdes recidivum*. But the question speedily became involved in complications, since Brandt,¹¹ of Fuessen; Friedrich Engelmann,¹² of Kreuznach; Adolph Kuehn,¹³ and Daniel

¹ Paris, 1874. "Sur l'Erythème Scarlatiniforme Rhumatismal."

² Union Méd., No. 29, 1876.

³ Paris, 1879, p. 18. "Etude sur l'Exanthème Scarlatiniforme."

⁴ Paris, 1877, p. 23 et seq. "Sur l'Erythème Scarlatinoïde Généralisé."

⁵ Paris, 1875. "De l'Erythème Desquamatif Scarlatiniforme."

⁶ "Remarable Case of Periodical Peeling of the Cuticle." (Lancet, Oct. 22, 1881.)

⁷ "Annales de Dermat. et de Syph," June, 1883.

⁸ "Corresp. Blatt für Schweizer Aerzte," No. 13, p. 391, 1876.

⁹ Ibid.

¹⁰ Ibid., No. 5, p. 134, 1875.

¹¹ Berlin Klin. Wochens., p. 718, Dec. 1, 1879.

¹² Ibid., No. 43, p. 647, Oct. 27, 1879.

¹³ Ibid., No. 4, p. 50, Jan., 1880.

Bernouilli himself,¹ were not slow in bringing forward cases of desquamative scarlatiniform erythema in which relapses had been caused by the administration of drugs, and in raising the question whether all previously-described instances of this complaint ought not to be regarded as belonging to the great class of medicinal eruptions. Thus, for example, in a paper by Allan Jamieson,² Cases 5 and 6, to which he gives the title of acute exfoliative dermatitis, were probably nothing but drug-exanthems produced by large doses of chloral, of bromide of potassium, and of salicylate of soda. Obviously, then, it is necessary to take this element into account when investigating the subject. I shall make all due allowances on that score; yet it is my firm opinion that genuine cases of primary desquamative scarlatiniform erythema have undoubtedly originated outside the sphere of any medicinal influence. Such are the cases which have fallen under my own observation, and which warrant me in presenting the following delineation of their type.³

Description.—An attack of relapsing desquamative scarlatiniform erythema is generally ushered in by the following constitutional symptoms. The patient first complains of slight malaise, a sense of painful lassitude, he is then seized with a rigor, which may be either slight or severe, and resembles that which precedes pneumonia; sometimes there are only frequent shiverings—in one case these continued for three days. Next, a febrile movement sets in, but its precise manifestations are difficult to determine, since patients seldom enter the hospital until three or four days after the commencement of their illness. From what they report, it would appear that the fever reaches its highest point during the first two or three days of the complaint. If this be so, it must be quite severe

¹ "Corresp. Blatt für Schweizer Aerzte," No. 2, p. 37, Jan 15, 1880.

² Edin. Med. Jour., 1880, p. 879.

³ It is not at present my intention to enter upon any detailed account of the pathogenetic scarlatiniform exanthemata, which ought strictly to be classed among artificial disorders. I will merely remark that they are usually of very brief duration, and may result from the ingestion of either food or drugs. 1st, *Foods.* Among fish, the gold-headed doree, carangue, herrings; the crustacea in general, as crabs, lobsters, shrimps, etc.: the mollusca, especially mussels; certain vegetable products, as strawberries and water-cresses. 2d, *Drugs.* Ether and chloroform, by inhalation: chloral hydrate (Watson); balsam copaiba; opium [Seguin (Arch. of Medicine, New York, p. 10, 1879); iodine (Fisher); Mercury [Alley, 1810, Briquit (Arch. Gén. de Méd., 1838 and 1839), Baron (Gaz. Méd., 1850), Watson (Boston Med. and Surg. Jour., July 18, 1878)]; sulphate of quinine [P. A. Morrow (New York Med. Jour., March, 1880), Heinrich Kobner (Berlin Klin. Wochens., No. 22, p. 305, 1877, and No. 23, p. 325), Scheby Buch (Ibid., No. 37, p. 547, 107, 1877), Pflüger, of Berne (Ibid.), Ricklin (Gaz. Méd. de Paris, 1877), Garraway and Hemming (Thèse de Jeudi de Grissac, 1875)]; datura stramonium and belladonna [Jolly, Dubreuil, Bazin, Tardieu, Hulinel, Dreyfus); benzoate of soda [Hampelin (St. Petersburg Med. Wochens., No. 3, 1881)]; opium and ipecac, ipecac and rhubarb, Dover's powder, calomel, etc.

at the outset, since it is not uncommon for the axillary temperature to range between 38° and 39° C. on the fourth or fifth day. The skin is hot; the pulse frequent (100 to 110). Nausea and retching are very rarely met with; there may be some anorexia, but it is never a decided symptom. No diarrhoea—the bowels are generally constipated. A good deal of pain is sometimes experienced in the back and limbs, as well as very severe headache; occasionally there is anxiety and insomnia. Frequent epistaxis may take place, the perspiration may be excessive, but in most cases is entirely suppressed. In this stage, however, the only constantly-observed symptoms are the fever and the state of general malaise.

These precursory phenomena are of variable duration; sometimes they are very short-lasting, and the eruption comes out almost suddenly; sometimes they continue for several days (three days in one of my cases) before the slightest redness is perceptible on the general surface. Quite often the eruption first shows itself in the form of small, red, itching spots accompanied with some swelling of the integument. Patients say that, in the beginning, they have frequently noticed a number of small, red, dry pimples, which subsequently enlarged and became confluent. In other cases, their attention was first attracted by a large patch of a uniform color, and which rapidly increased; sometimes again the bodily surface presents a scarlet hue, or is covered with minute red papules, which change into a uniform investment of the same color. The itching in some cases is severe enough to compel scratching; in others it is hardly noticed, being thrown into the shade by a pricking, a smarting, or a sense of pungent heat, which is almost intolerable.

These distressing phenomena may precede the appearance of cutaneous redness; but they are not constant in their occurrence; they may be very moderately felt, or almost entirely absent; and however severe at their outset, they speedily subside, and may even cease altogether before the eruptive process is completed.

It is hardly possible to indicate the precise point at which the cutaneous manifestations take their rise, but it is certainly a very variable one. The eruption may begin on the upper portion of the body, and travel downward to the feet (Féréol's cases), or its advance may be in the opposite direction. In one case, its earliest appearance is on the superior and internal surface of the thighs; in another, it first invades the wrists, extending in succession to the arms, the forearms, the axillæ, the legs, and the body; in still other instances, it seems to have attacked several localities simultaneously.

Wherever it may begin, it tends to diffuse itself over the whole surface, most frequently reaching this consummation very speedily, even within the first twenty-four hours, although in some very rare instances from four to six days may be required. The head and the extremities—

hands and feet—are apparently the last parts to be invaded. In what we judged to be two cases of this disease, the head remained entirely untouched, which would seem to show that the eruption may sometimes not be universally diffused.

When completely developed, it is characterized by an intense and uniform redness, which, however, exhibits brighter or darker shades at different localities. The face is usually less discolored than any other part, though sometimes it is as red as the body. The anterior portion of the neck and chest is not so red as the nape of the neck, the back, and more especially the abdomen, in which situations the eruption assumes a somewhat darker tinge. The outside of the arms is often lighter colored than the rest of the upper extremities. The external surface of the thighs is likewise of a paler hue than the internal, and also than the legs. The palms of the hands and soles of the feet, owing to the thickness of their epidermis, show but little redness until desquamation has taken place.

Under finger-pressure, the cutaneous redness in most cases almost wholly disappears, and is replaced by a slight yellowish tint; not infrequently, however, this effect is only partially produced, the resulting color being a reddish-yellow. In one case, the eruption was observed to assume a hemorrhagic appearance, and in a patient of my own, it was accompanied by a considerable degree of general œdema, which extended even to the face. Most generally the integument shows a little puffiness at an early period, but this quickly disappears, so that only a slight thickening of the skin can be perceived on pinching it up between the fingers. The fact, moreover, that the change in question involves the whole cutaneous system, renders it in this instance still more difficult of detection. Yet, in one very well marked case, a certain degree of œdema could be made out as late as the fourth day of desquamation (eighth of eruption), in consequence of the patient's forehead pitting slightly under pressure.

When the redness has lasted a certain time, it is succeeded by *desquamation*. This sets in about three or four days after the eruption has overspread the entire surface, but the exact time varies in different cases. In some it seems to have been shorter than the above; in others, desquamation was delayed until ten days after the eruption had declared itself. The length of the interval must evidently depend upon the intensity of the morbid process, and upon the rapidity with which the general integument becomes involved, since, when several days are required for the full development of the eruption, those patches which were first formed will be the first to desquamate, and will have passed through this stage before the eruption has completed its extension; such cases, however, as we have already remarked, are very exceptional.

The desquamation commences with a small superficial fissuring of the epidermis; the cracks widen and extend, the epidermis between them rises and loosens, turns to a pearly white, and gradually becomes detached in flakes. It is difficult to say where this process commences; possibly it follows the same course as the preceding discoloration: at all events it may be affirmed that desquamation takes place wherever there has been redness. It is chiefly distinguished by its dryness and excessive abundance, the scales being swept in handfuls from the patient's bed every morning (in one case, three litres of them were accumulated in five days). On certain localities the scales are furfuraceous, but almost universally they appear as large, very thin and transparent flakes; sometimes, however, they are thick, yellowish and opaque, or thin, and of a dead white color, like unpolished glass. They occasionally measure as much as several centimetres in diameter, by one or two in height, are quite irregular in shape, and often shrivelled or frilled at their free borders. They may be adherent at one of their sides, all the rest of them floating loosely; or they may be fastened at the centre,¹ their unattached portions resembling a lady's lace collar. From a descriptive point of view, they are divisible into two classes: 1st, the *full-grown scales*, which are almost ready to fall off, and for the most part are large and but slightly adherent; these overlie, 2d, the *immature scales*, or those in the earlier stage of their growth, fine, furfuraceous, scarcely visible, and firmly adherent. Upon this second layer there is microscopically discernible a series of small, hard, white elevations, formed by an accumulation of epidermis in the glandular orifices. When the difficult task has been accomplished of scratching off all the scales, a smooth, glistening, and somewhat moist surface is disclosed. The eruption itself is always dry, never exuding in the least, even at the bends of the joints, except under the influence of irritating applications. In a single case, moisture was observed upon the genital organs.

It will readily be understood from this description that the general appearance of the affection may vary from time to time, according as the skin is covered with full-grown scales or with those that are immature.

On the *scalp*, the *eyebrows*, the *beard*, and the *mustache*, the scales are fine, furfuraceous, very abundant, and firmly adherent, sometimes forming a thick mass of a yellowish-white color. They are perforated vertically by the hairs, and do not overlap them, as in eczema. On the *forehead* and *eyebrows* they are fine, but already somewhat lamellated. They are frequently found in thick layers at the root of the nose, at the naso-labial furrow, and in the concha of the ear. On the *tip of the nose* they are very fine, somewhat thick, and quite broad; on the *cheeks* they are furfuraceous. The *face* presents a floury appearance, which would make it

¹ *Vide* description of the scales in general exfoliative dermatitis.

a good deal like that of the clown in a pantomime—provided that the clown's skin underneath were of a bright red color.

On the *neck*, the full-grown scales attain their largest size. All over the *body*, they are large, thin, uneven, rolled up at their free edges, or of a dull white color. On the *deltoid region*, they are thin and transparent, although still of a dull white color, slashed and curling at their free borders, and measure three centimetres in diameter by one in height. In one case, I found the *inner surface of the arms and forearms* covered with thick scales, almost yellow at some points, opaque, and forming a sort of shell like that of a turtle, loosely adherent and crossed diagonally by small superficial wrinkles. These scales, at first sight, irresistibly remind the observer of psoriasis. I cannot say whether such an arrangement is frequently met with.

The *back of the hands* not infrequently exhibits a very peculiar kind of desquamation—the scales, which measure several square centimetres, being transparent, but thick, hard, and, as it were, glued upon the skin, from which they are only slowly and gradually detached in the course of several days. This appearance is also especially well-marked on the *palms of the hands and on the fingers*; the skin of the latter, previous to desquamation, is tense, shining, hard to the touch, and apparently somewhat elastic. They appear as if covered with a thick layer of collodion or of court-plaster. Then the epidermis becomes yellowish and peels off in broad, hard, almost horny flakes, which sometimes form only a single layer on the palmar surface of the hands, exactly corresponding to the glove-like desquamation observed in scarlatina. Here the process takes place much more slowly than on the rest of the body. When this first layer hardens and falls off, it leaves a red or pinkish surface dusted over with a few fine furfuraceous lamellæ, but these are never followed by the large flaky formations which have just been described.

Over the *pubis* is found an accumulation of epidermic scales. The genitals and cleft of the anus are of a bright red color, and scantily covered with small thin scales. On the *thighs and legs* the scales are large, of a dull white color, and curly at their edges; they attain their greatest size in the neighborhood of the *knees and instep*, where they measure as much as 5 to 6 centimetres in diameter, and resemble leaves of gold beaters' skin. The soles of the feet, like the palms of the hands, desquamate quite slowly, and their epidermis comes off all at once in the form of sandals.

The *mucous membranes* are not always exempt from the above visitations. Thus, in seven out of eleven carefully observed cases, the affection began with an *erythematous angina*, not at all severe, it is true, but distinctly characterized by some degree of dysphagia, and by marked redness of the isthmus faucium. In several instances, the *conjunctivæ*, especially

of the eyelids, have been injected and painful; but the functional symptoms of blepharitis do not seem to be uniformly in correspondence with these phenomena, since, in one of my cases, the patient made no complaint of "sand in his eyes," although the conjunctivæ were bright red. In most cases, the *tongue* at the outset is rather white, then it seems to part with its epithelial investment, becoming smooth, glazed, raw-looking, and of a bright red color. Sometimes there is a sensation of dryness and pricking in the organ.

Among the epiphenomena of the eruption, *miliaria* have been noticed in one case at its commencement—a rare complication, apparently; in another, which fell under my own observation, there was an outbreak of *fever-sores* on the nose and lips. In the instance recorded by Homelle, the epidermis was raised in bullæ, like those caused by a fly-blister, upon the legs and instep; the eruption was likewise somewhat moist over the lower portion of the thighs.

Almost all the patients complained that their skins felt dry. The insensible perspiration seemed entirely suppressed, in these cases. Quite frequently, a marked sensation of coldness was experienced after undressing.

Constitutional symptoms are almost wholly absent after desquamation has set in. During the first days, the fever is still quite high towards evening ($38-38.5^{\circ}$ C.; pulse 80 to 100); but soon disappears entirely. The patient's appetite returns, and his strength is fully restored, even before the termination of the eruptive stage. The itching and smarting sometimes persist to the very last, becoming, however, much less troublesome. In one case, there was such urgent thirst, that the patient drank about six litres of *tisane* daily, and his kidneys were acted upon accordingly. Neither sugar nor albumin, however, has been detected in the urine. Bronchial and cardiac complications are equally unknown. Almost all the subjects declared that, were it not for the redness and desquamation, they would have felt as well as usual.

Course—duration—termination. Desquamation generally goes on as above for about a week, during which the complaint remains stationary, then gradually becomes finer and more furfuraceous until it ceases, after a period varying from a week to a month, but averaging fifteen to eighteen days. The redness may disappear very rapidly, but in most cases becomes more intense as desquamation approaches; sometimes it continues throughout, but gradually loses its vividness and assumes an earthy appearance.

The last traces of the eruption are visible on the *nails*. A furrow, more or less deep according to the intensity of the desquamative process, is formed across the roots of those organs; and when, as is not infrequently the case, there are several successive attacks of erythema, each

one of them gives rise to a fresh furrow, so that a single nail may exhibit several. The nails of the thumb and index finger are those which are most conspicuously marked in this way. When desquamation has been very active, the groove will be especially deep—so deep as apparently to separate the nail into two distinct portions, an anterior and a posterior (the latter being that which is formed after the eruption). The anterior portion is gradually pushed forward by the newly-formed layers, which may even replace it from underneath. Hence it is that in some cases the old nails are said to have fallen off at the end of three or six months, after having been lifted out of position by the new ones. In one case, however, we observed that the nail of the little toe fell off on the twentieth day of the affection; perhaps the more important nails may in other instances have been detached as rapidly, but we have never met with any distinct statement to that effect. It does not appear that in this affection mortification of the entire matrix unguis and sub-ungual derma has ever taken place, as it does in cases of exfoliative dermatitis. We are supported in this opinion by the fact that falling of the hair is quite an exceptional phenomenon in desquamative scarlatiniform erythema, while it is the rule in general exfoliative dermatitis. These positions, however, are by no means taken unreservedly, since, in three cases of what appeared to be genuine relapsing desquamative scarlatiniform erythema, the hair is stated to have fallen off during the first attack, which was a very protracted one. This would seem to show that it is hardly possible to demonstrate any radical difference between an initial invasion of erythema and a slight attack of general exfoliative dermatitis.

Relapses.—One of the most striking characteristics of desquamative scarlatiniform erythema is its tendency to relapse, and that not once only but repeatedly. A first attack is usually a very serious affair, lasting from a month to six weeks, and sometimes resulting in the loss of the hair and nails; then, after an interval varying from a few months to several years, there may be a second one, not so severe. This is soon followed by a third, after which successive seizures occur with increasing rapidity, until they may even merge into one another, as in the cases recorded by Féréol and Richardière. At the same time they seem to become shorter and milder. If the hair and nails have been lost in consequence of the first attack, they are affected but slightly by the second, not at all by the third, etc. The duration of these relapses may be a fortnight, or even less (Tilbury Fox). They may occur once a year, as in Gooch's and Latham's cases, or twice a year, as in my own and Newell's. Féréol's patient was having the disease for the eighth time, as also was Richardière's; Colard's for the seventh. Tilbury Fox's had had 100 returns of it at least.

I cannot say positively whether this complaint relapses as a uniform

rule; very possibly it does not. In this case ought the group under consideration to be divided into two sub-varieties—1st, *Relapsing desquamative scarlatiniform erythema*; 2d, *Non-relapsing ditto*—and should these sub-varieties be regarded as distinct affections? Further investigations are required for the settlement of these questions.

Histology.—The pathological anatomy of desquamative scarlatiniform erythema is as yet wholly undetermined. It is so closely related, however, to general exfoliative dermatitis, that the two complaints should present almost identical lesions (vide general exfoliative dermatitis).

Etiology.—Desquamative scarlatiniform erythema is a rare disease. All told, I have scarcely been able to collect fourteen indisputable cases. The doubtful instances are much more numerous. It affects persons of every age, but from 20 to 40 is the period of greatest liability to a first attack. It occurs most frequently in persons but little subject to perspiration—whose skin is habitually dry. Concerning the influence of occupations nothing of importance has been ascertained. Of the above-mentioned fourteen cases, eleven were men and three women, from which it would seem that the male sex is more predisposed to the complaint. Scrofula appears to take no part whatever in its development; but so much can hardly be said of the arthritic diathesis, since several patients were ascertained to have previously suffered from pains in the joints, hemorrhoids, and dyspepsia. As to the effect of the seasons in advancing or retarding the eruption, the evidence at hand does not enable us to speak with certainty.

Diagnosis.—To distinguish desquamative scarlatiniform erythema from *scarlatina* is at once easy and extremely difficult—easy when the eruption has already made repeated appearances; difficult when we have a first visitation of the malady to deal with. Frequently, in the latter event, we imagine that a case of eruptive fever is on our hands, until the redness is seen to continue after the eighth day of the exanthem, and desquamation has occurred several times and become exceedingly abundant, when we are compelled to a diagnosis of desquamative scarlatiniform erythema. The onset of the latter, also, is less abrupt than that of scarlatina; the febrile reaction is perhaps less severe; the angina not so marked, or possibly absent altogether. On the other hand, the redness of the skin is much more pronounced; miliaria are of rare occurrence; desquamation is far more abundant and frequently repeated, and exhibits much more of a lamellated character. The local symptoms, too, are very decided, while constitutional symptoms are trivial or wholly wanting. The complications (buboes, endocarditis, renal congestion, etc.) so frequent in scarlatina, are never observed in scarlatiniform erythema. Finally, the latter affection is non-contagious. Notwithstanding all these distinctions, desquamative scarlatiniform erythema was confounded

with scarlatina, even down to recent times, and this fact affords an explanation of certain anomalous features which have been ascribed to the more familiar affection (long duration, relapses, etc.).

The slight and transient *scarlatiniform erythema* described by Hardy is distinguished from desquamative scarlatiniform erythema by its brief duration—forty-eight hours in the average—by its benignity, and by its very scanty and furfuraceous desquamation.

I need not dwell upon the differential diagnosis, in each particular case, between desquamative scarlatiniform erythema and *erysipelas*, *lymphangitis*, *eczema rubrum*, *scarlatiniform psoriasis*, *exfoliative herpes*, and *pityriasis rubra pilaris*, from all of which it is readily distinguished by its universally diffused redness, the abundance and peculiar formation of its epidemic scales, the dryness of its eruption, and the regular stages through which its evolution is accomplished. Its relations with *general exfoliative dermatitis* and with *pityriasis rubra*, both serious and benign, will be discussed on a future occasion.

It has been already mentioned that the disease we are considering cannot be regarded as simply the result of drug-medication, as identical with the *pathogenetic desquamative scarlatiniform erythema*. The cyclical character of its development, and its protracted duration, suffice to set it widely apart from eruptions that are purely artificial, and that usually disappear immediately on the suppression of their causes.

Prognosis.—The prognosis in cases of desquamative scarlatiniform erythema is decidedly favorable. The cutaneous manifestations usually subside within a determinate period without occasioning any serious disturbance. The possibility of an indefinite number of relapses affords the only ground for apprehension.

Treatment.—When attending a first attack of desquamative scarlatiniform erythema, and not quite sure of our diagnosis, we should be guarded in our expressions of opinion, and should treat the case as one of scarlatina, keeping the patient in bed, protecting him against cold, and being careful that he does not overeat. When in no doubt as to the nature of the case, we may endeavor to allay the violence of the eruptive symptoms, and to moderate the desquamation, by inunctions with a glycerole either of simple starch, or containing one gramme of tartaric acid to twenty grammes of glycerole. Simple ointment is likewise an excellent application, provided it is quite fresh, and the same may be said of vaseline. Frictions with linseed-oil and lime-water may also be employed, after which the surface should be covered with layers of wadding. Sedative baths have also an excellent effect. As to internal medication, I believe it best to abstain from all powerfully acting remedies, especially arsenic. We should be content with prescribing some alkaline mineral water, as that of Vals or Vichy, a bitter *tisane*, the free use of

milk as a diuretic, saline purgatives, if the bowels are unduly confined, and in general a wholesome, progressive, and invigorating dietary, excluding all highly-seasoned and irritating articles.

RECENT ADVANCES IN DERMATOLOGICAL THERAPEUTICS.

BY

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IT is undoubtedly the general verdict of every intelligent physician in general practice that the treatment of cutaneous diseases, as a whole, is not generally as satisfactory, either to himself or patient, as other departments of practice. The principal reason for this is the little attention given to the subject by the general practitioner.

While I may not be able to instruct you, yet I hope to gain a sufficient amount of your attention to awaken an interest and stimulate a desire for investigation in this department of the practice of medicine.

The methods of treatment which I have outlined are a review of some of the more recent advances in cutaneous therapeutics.

It is not to be understood, however, that the remedies mentioned in this paper are recommended as the best or only remedial agents to be used in each instance in the management of the various diseases under consideration to the exclusion of other and well-recognized plans of treatment, but as supplementary thereto.

I wish to direct your attention, first, to a class of preparations but a very few years ago introduced into cutaneous therapeutics, and known by the general designation of the oleates.

The advantages which it is claimed the oleates possess over ordinary ointments are the following:

- 1st. Their deep penetration.
- 2d. Their freedom from rancidity.
- 3d. Their cleanliness of application.
- 4th. Their great economy.
- 5th. Their antiseptic and deodorant properties.

A long list of substances have been included in the oleate preparations.

Among the number may be mentioned copper, mercury, bismuth, zinc, etc. These preparations seemed to gain their popularity by the success achieved by an ointment of the oleate of copper in the treatment of ringworm. The oleate of copper is an excellent application in ring-

worm. The oleate of mercury would be indicated in the inunction treatment of syphilis, and in the various parasitic diseases. The oleate of bismuth would be useful in rosacea, and zinc oleate in vesicular eczema, and excessive sweating or hyperidrosis. Dr. Shoemaker, of Philadelphia, reports favorably on the use of the oleate of copper in the removal of freckles or lentigo, yet he does not claim that it is a specific for this disfigurement. It will be remembered that Dr. Shoemaker is an enthusiastic advocate of the treatment of skin diseases by the oleates. Whether the oleate of copper will prove itself a better remedy in lentigo than a solution of corrosive sublimate remains for the future to decide. There is no question but that the oleates are a valuable addition to the therapeutics of skin diseases.

At the recent meeting of the Pennsylvania State Medical Society, held the last week in May, Dr. Shoemaker spoke of medicated soaps. Potash and soda soaps are medicated with tar, naphthol, carbolic acid, salicylic acid, sulphur, balsam of Peru, alum, camphor, eucalyptol, corrosive sublimate, etc. They must be used with caution, as they are productive of harm as well as good, and they should not be relied on exclusively.

Dr. Engelsted, of Copenhagen, Denmark, made a report some time ago in regard to the use of naphthol in skin diseases. This remedy was first proposed by Kaposi, of Vienna, as a remedy in scabies. Kaposi recommended an ointment composed of fifteen parts of naphthol, ten of of chalk, fifty of green soap, and one hundred of lard. The results reported by various dermatologists do not correspond, as might be supposed. Engelsted is not inclined to regard it with much favor, except, possibly in scabies, while Van Harlingen, of Philadelphia, is especially pleased with its action in scabies, and regards it as a valuable addition to the external treatment of psoriasis. In eczema, seborrhœa, and ring-worm, he has not obtained the brilliant results claimed by Kaposi. In psoriasis it is used in the proportion of forty-five parts of naphthol, one hundred of water, and two hundred of alcohol. This solution is applied to the scaly portions of the disease morning and evening. It cannot be used many days at a time on account of the irritation it produces. Engelsted does not consider it as valuable as chrysarobin in the treatment of psoriasis. It is useful in a weak solution to allay itching.

Dr. Corlett, of Cleveland, O., recommends bromide of arsenic internally, and chrysarobin pigment externally in psoriasis.

Dr. George Henry Fox, in the second edition of his "Photographic Illustrations of Skin Diseases," speaks of a combination of chrysarobin, salicylic acid, ether, and collodion for the external treatment of psoriasis. The formula which he advises is as follows:

Chrysarobin	10 parts.
Salicylic acid.....	10 “
Ether	15 “
Flexible collodion.....	to 100 “

This combination is known at the New York Skin and Cancer Hospital as the “Compound Chrysarobin Pigment.” Dr. Fox speaks very highly of this treatment. Chrysophanic acid causes more staining of the integument, and sometimes excites a pretty severe dermatitis, besides injuring clothing. This combination of chrysarobin does not produce these unpleasant effects.

Dr. H. G. Piffard, of New York, recently recommended bromide of arsenic in doses varying from one one-hundredth to one-fiftieth of a grain, two or three times a day, in acne vulgaris.

Dr. Morrow presented a case of eczema of the leg at a meeting of the New York Dermatological Society, February 26, 1884, treated with medicated gelatin plaster. The following formula was used:

Glycerin	250 parts.
Gelatin.....	1000 “
Water.....	2000 “

This was medicated with ten per cent of oxide of zinc and one per cent of carbolic acid. This was applied to the diseased skin, and allowed to remain a number of days. It forms a firm, protective coating, and retains the medicinal application evenly in contact with the disease. Another way of preparing plasters is to spread a coating of the medicated gelatin or other combination on muslin. The muslin can then be cut in any desired shape, and made to fit any inequality of the surface.

Dr. W. T. Alexander, of New York, recently called attention to the success he had met with in treating ringworm of the scalp, in a public institution, by the use of a ten-per-cent solution of chrysarobin in liquor gutta-percha. This pigment was painted over the diseased ring with a brush, and allowed to remain a number of days.

Within the past year, a mode of preparing medicated powders for moist skin affections was brought to the notice of American dermatologists by Dr. Faithful, of Australia. The remedy is first dissolved in alcohol, ether, or chloroform. The solution is then mixed with starch or French chalk, and the alcohol, chloroform, or ether allowed to evaporate. The evaporation should be conducted without the aid of heat. A fine medicated starch or chalk-powder remains. Various remedies may be prepared in this way. Vesicular eczema, intertrigo, herpes, ulcers, etc., may be treated with these powders. “Anderson’s Dusting Powder,” an old, but valuable remedy, is useful in the same conditions. This powder is composed of one-half ounce of zinc oxide, one drachm and a half of camphor, and one ounce of starch.

The somewhat remarkable statement has been made that a crop of warts has been removed from the hands by daily ten-grain doses of calcined magnesia, taken in the morning before breakfast. It has the merit of being harmless and simple, but I doubt very much the efficacy of the treatment.

Alder Smith recommends seven grains of chrysophanic acid to one ounce of chloroform in the treatment of ringworm.

Resorcin, a preparation from various gum resins, has been recommended in eczema, erysipelas, ulcers, wounds, and epithelioma. It is used in the proportion of one or two parts to ten of vaseline. It has not been used very extensively, and does not seem to have proven itself a very valuable addition to the therapeutics of the diseases mentioned.

Dr. R. W. Taylor, of New York, recommended a measure, last year, in the treatment of eczema marginatum, and of ringworm in general, of using a solution of corrosive sublimate in tincture of myrrh, or compound tincture of benzoin. Two to four grains to the ounce is the strength used. It is perhaps as well to commence with the weaker solution. The principle of using the benzoin or any of the gum resins is to furnish a vehicle for retaining the corrosive sublimate in contact with the diseased patch of skin. It is not thought that the tinctures have any therapeutic effect on the disease.

Dr. S. Sherwell, of Brooklyn, read a paper before the annual meeting of the American Dermatological Association, in August, 1884, on the treatment of acne and rosacea in the male subject. He made the basis of his remarks some old chronic cases of acne and rosacea. They had resisted every plan of treatment. They were finally relieved of the disease and its annoying disfigurement, by the introduction of the cold steel sound. The sound was passed every third day for a time, gradually increasing the interval to once a week, as improvement followed.

At a meeting of the New York Dermatological Society, held March 24th, 1885, Dr. George Henry Fox made some remarks concerning the balsam of Peru, combined with the various metallic oxides, as an adhesive dressing in skin diseases. Zinc, bismuth, magnesia, etc., may be thus combined. He also spoke of the treatment of psoriasis by salicylic acid in castor oil. Two to five per cent is the strength ordinarily used.

In the April number of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES for this year, is a note from Dr. Greene, of Christiania, recommending iodide of potassium in fifteen-grain doses three or four times a day, gradually increasing it, for psoriasis.

Pyrogallie and salicylic acids have been recommended in the treatment of chaneres and venereal ulcers. Of the two, the pyrogallie has the greater weight of evidence in its favor, as being more prompt and

certain in action. It should not be combined with soap or other alkali, as it is thus readily decomposed.

Calx sulphurata, an article brought into prominence about fourteen years ago by Dr. Sydney Ringer, as a remedy in furuncles, is of value in other skin affections. Cane reported favorable results from its use, in 1878, in acne, and in eczema rubrum.

One of the latest remedies for psoriasis is the fluid extract of burdock seed. It is recommended in the doses of twenty drops to one drachm three times a day. I have used it with apparent benefit, but I have not had an opportunity of testing it sufficiently to be able to report intelligently in regard to it. It has been spoken of favorably by a number of physicians, yet it does not seem to have gained the confidence of those who know the most of dermatology.

Dr. E. L. Keyes, of New York, read a paper before the New York Dermatological Society, the first of this year, entitled "Note on Hydrochlorate of Cocaine—Its Possible Dermatological Uses." Briefly, it is recommended in cutting out small tumors, opening abscesses, in epilation, applying caustic to syphilitic sores, etc. There is no doubt but that it can be used to good advantage in many skin affections.

I wish to say a few words in regard to *phytolacca decandra*. It is well known that this remedy possesses the remarkable power of arresting glandular inflammation, especially of the mammae. The thought has occurred to me, of late, that it might prove advantageous in acne, and possibly in comedo and seborrhœa. I have not had occasion to try it as yet, but intend to give it a trial at the first opportunity. It may not be of any value, but a thorough test of it would do no harm.

Selections.

THE PATHOLOGY OF RODENT ULCER.

WRITINGS on the microscopic characters of rodent ulcer may be said to have originated in the well-known monograph by Thiersch, on epithelial cancer, published in 1865. Anterior to this, the clinical features of the disease had been very carefully studied and described by Jacob, Paget, Hutchinson, and Lebert; and though they recognized its distinct identity as an infiltrating and ulcerating growth of a specific nature, a better knowledge of its minute structure was required to avoid the very natural difficulty of confounding it with lupus, syphilis, tuberculosis, or epithelioma. Thiersch's contribution is in every way worthy of the position which it occupies, and the illustrations accompanying the text show the author's clear conception of the histological features of this disease, which he

described as flat epithelial cancer, in contradistinction to the ordinary infiltrating form of epithelioma. Though regarding rodent ulcer as a variety of epithelioma, his researches encourage the opinion that it has a special origin in the sebaceous glands. Other observers soon followed, and their writings are without exception the result of careful and thorough investigation, becoming more and more valuable as the work of the microscope has become more and more perfect. In 1867, Mr. Moore, of the Middlesex Hospital, published his pamphlet, in which he described rodent ulcer as a form of epithelioma. In 1871 and 1873, Mr. Hulke expressed similar views at the Pathological Society. In 1872, Dr. Collins Warren, in his Boylstonian prize essay, maintained the opinion that the growth commenced in a small-cell exudation, which developed under the influence of the rete Malpighii; this, of course, must be regarded as a variety of the epithelioma view. In 1878 and 1879, Dr. Thin, at the Pathological Society, originated and supported what has since been called the sweat-gland theory. In 1879, Drs. Tilbury and Calcott Fox, at the same Society, read their paper in support of the opinion that the growth started in the root-sheath of the hairs; Mr. Butlin, in the discussion which followed, supported the sebaceous gland theory of Thiersch. In 1882, Dr. Sangster, at the annual meeting of the British Medical Association, read a paper also in support of the root-sheath view; and an additional paper, tending in the same direction, has since been published in the *British Medical Journal*, by Mr. Hume, of Newcastle.

There has then been a considerable diversity of opinion concerning the true nature of rodent ulcer, since the appearance of the writings of Thiersch. They may be classified as follows:

1. As a variety of epithelioma—Moore, Hulke, Collins Warren; and as depending upon the nature of the soil in which it grows—Hutchinson.
2. As a carcinoma of the sebaceous glands—Thiersch, Butlin, and others.
3. As a carcinoma of the sweat glands—Thin.
4. As a carcinoma of the hair-follicles—Tilbury and Calcott Fox, Sangster, and Hume.

The present communication is based upon the microscopic examination of twenty-two cases, in all of which the entire growth has been excised with the knife, and placed in my hands for investigation. Twenty of them were clinically unmistakable, the other two were doubtful. A few more cases of chronic epithelioma of the hand were clinically regarded as allied to rodent ulcer: but, since their structure is distinctly epitheliomatous, they are not included, though it is quite possible that they have equal claims to be. It would occupy too much space to describe the cases individually; and I shall, therefore, be content with generalizing some of the broader clinical facts, asking that the diagnosis may be accepted as correct, on the ground of the clinical experience of the observers, confirmed, if you will, by a personal examination of the specimens, as there are microscopical preparations here from every one of the cases.¹

The strange observation that rodent ulcer is, with very rare exceptions, limited to the face, is borne out by these cases, as all occurred in the skin of the face. Seven were on the cheeks; seven on the eyelids (the two doubtful ones both on the upper eyelid); three on the forehead; three on the side of the nose; and two

¹ The specimens, which were shown in the Section of Pathology at the annual meeting of the Association in Belfast, were obtained as follows: five from Mr. Bickersteth; two from Mr. Reginald Harrison; two from Mr. Mitchell Banks; three from Mr. Rushton Parker; two from Mr. Shadford Walker; two from Mr. Edgar Browne; one from Mr. Puzey; one from Dr. Little, and four were my own.

in the skin of the lips, one the upper and the other the lower, but both quite away from the red border. Sixteen occurred in males and six in females, bearing out the general opinion that the disease is more common in men than in women. The average age of commencement was 50, varying from 35 to 72; the earliest cases being in women. The great length of time occupied by an ordinary rodent ulcer in attaining a sufficient degree of severity to awaken any apprehension in the class of people who are usually attacked by it, is such as to mislead us to a certain extent as to the age when it commences; and I am sure that it ought not to be regarded as a very uncommon occurrence in the fourth decade of life. The average duration of the disease before operation was six years, varying from six months to fourteen years. This fact is, of course, of no great value, as the disease varied proportionally in extent, except that it is in accordance with the usual experience of the chronic nature of the growth. Those ulcers which were of short duration were small, shallow sores, covered with a scab, and showing the characteristic pale raised border of infiltration; while in one case the growth was a mostly subcutaneous nodule in the loose skin of the lower eyelid. The older growths had all the usual rodent characters, destroying the skin, muscle, eye, bone, etc., just as they happened to fall within the area of infiltration.

The specimens have generally, and always recently, been prepared by hardening the tissue in bichromate of ammonia, and subsequently in spirit; the sections have been cut by Bevan Lewis's microtome, stained in logwood and eosin, and mounted in Farrant's solution. The sections have, of course, always been taken through the growing margin into the surrounding skin, which has in all cases been carefully examined.

It is not necessary, at the present time, to say anything in reference to the purely carcinomatous type of the disease; that is admitted on all hands. I have, therefore, directed my attention entirely towards elucidating to what variety of carcinoma rodent ulcer belongs; or, in other words, of what epithelial tissue it is an atypical form. In some cancers this is a point which is easily decided; for instance, in epithelioma, cylindrical epithelioma, and some thyroid, hepatic, and other cancers. In others, it is equally difficult. Take, for example, an ordinary scirrhus of the breast. This is so mildly typical of breast-tissue, that most pathologists, even now, regard a scirrhus of the breast as a type of cancer which may occur at any part of the body, when it cannot possibly bear any other relation to a primary cancer of another organ, than that they are all epithelial new growths.

Rodent ulcer also is so slightly typical of any epithelial cutaneous structure—or, rather, it is so liable to show relationship with all the dermal epithelial evolutions, that great difficulty is met with in attempting to class satisfactorily.

It being accepted that rodent ulcer is a carcinoma of the skin, we have to decide whether it must be regarded as a carcinoma of the entire skin, or only of one of the dermal appendages; and if the latter, whether it is always an atypical growth of the same appendage, or whether it should be subdivided into carcinoma of each variety of appendage. With these difficult questions in view, I propose to consider:

1. The minute structure of the growth;
2. What normal skin elements, or other skin-growths, show any relationship to this;
3. Whether it has any special affinity for, or tendency to spread in one particular skin-structure rather than the rest;

4. Whether its remarkable localization to the skin of the face bears upon its origin;

5. Whether any microscopical evidence can be obtained as to its earliest formation—that is, the primary growth, not the marginal increase.

1. *The Minute Structure of Rodent Ulcer*.—Carcinoma, in whatever organ it develops, is liable to vary in its minute structure. In one typical form, the epithelial elements are arranged in acinous groups; in the other in duct-like columns of cells. The former is usually designated acinous cancer, the latter tubular cancer; and although, for purposes of classification, it is convenient to make this a clear distinction, it is really only an artificial one. For instance, in a series of cases of cancer of the breast, I find a large majority of specimens of acinous cancer, and very few of pure duct-cancer, and an intermediate group passing from one to the other. The same condition certainly holds good in carcinoma of the liver and prostate, and probably of all other acinous glands; but in strictly speaking tubular glands, such as those of the intestine, the carcinoma is almost constantly tubular. It seems not unlikely that this difference in structure depends upon the degree of evolution attained by the carcinoma under examination. A tubular growth is more embryonic than one that has attained to an acinous development. Thus a tubular epithelioma is one which consists solely of epithelial cells, resembling those of the rete mucosum. An acinous epithelioma, on the contrary, shows horny and nested cells—that is, the highest evolution of epidermal cells. A duct-cancer of the breast resembles the immature tissue of the virgin gland, an acinous cancer the fully developed organ of pregnancy. Rodent ulcer follows this general direction. It is sometimes absolutely tubular, sometimes transitional, frequently entirely acinous. Taking the two extremes, it is difficult to recognize them as being the same class of growth, but the chain of intermediate cases is so complete as to leave no doubt of their association.

Beginning in the skin, the various forms of rodent ulcer extend, after the manner of epithelioma, in all the elements of the skin itself, and in all the adjacent tissues; avoiding only that which is so readily infected by other kinds of carcinoma, namely, the lymphatic system. In the acinous variety, the groups of cells are strikingly disposed like those of epithelioma; and also like them, the marginal cells are cubical or cylindrical, and placed vertically upon the surrounding layer of connective tissue. The bulk of each acinus is made up of elongated cells, often very irregularly arranged; their disposition has been very aptly described by Sangster as though disturbed by opposing currents. Those which are next to the marginal layer have frequently their long diameters disposed at right angles to the cylindrical cells; but there is no constancy in their manner of arrangement, nor indeed in their character as cells. The marginal cells are usually epithelial-like, smaller and more delicate than those of the rete Malpighii, or of an epithelioma, but distinctly the same variety; whereas the intermediate cells are very sarcoma-like, or remind one very strongly of the spindle-shaped cells in an embryonic hair-bulb. Frequently, however, they are rounded or irregular in shape, but always much smaller than in epithelioma. The central portion of the acinus is yet more variable. Very large acini usually contain only a little central *débris*, which falls out in the section; others are filled with a delicate mucous tissue very poor in cells; and the remainder—no inconsiderable number of the whole—with nested cells; nested cells which are sometimes the result of a central aggregation of degenerated cells, unstainable, and therefore forming soapy-looking pseudo-pearls; or the result of endogenous multiplication, when the cells are

large, epithelial-like, and stain brightly. In size, the acini are often the equivalent of those of sebaceous glands, sometimes they are smaller than this, often many times larger. The central structure, when myxomatous, not unfrequently breaks up the mass of the acinus into a network of epithelial cells supported by mucous stroma. I have specially noticed this in deep infiltrations in the orbit.

Tubular rodent ulcer is far less common than the acinous variety. Perhaps it is never absolutely pure, though occasionally the structure appears almost uniform throughout. The most pure tubular structure was met with in a very small rodent ulcer of the nose. It consisted of columns of cubical cells, in some parts almost exactly like a sweat-gland; in others the lumen was filled with spindle-cells, which here and there so distended the tubes as to resemble an acinous development; but there was no central aggregation of cells into a pseudo-pearl, nor any central *débris*, nor other specialized tissue. The intermediate cases resembled generally the acinous variety, but in some parts fell off into a more or less perfect tubular structure. In no variety of rodent ulcer can the epithelial cells be said to attain to a distinctly horny character, nor to show the typical prickles of the cells of the rete mucosum like epithelioma; but the occurrence of nested cells is certainly not uncommon.

In addition to what may be called the normal varieties of rodent ulcer, the twenty-two cases include two distinctly aberrant forms of growth; one occurred in the upper lip of a woman, aged 58, quite away from the red border, as a thick infiltration, ulcerated in the centre. It had existed three years, and was considered by Mr. Bickersteth to be a rodent ulcer. Throughout almost the whole of the growth, the infiltration consisted of large spherical acini of uniform appearance, almost touching each other; each acinus consisted of a marginal layer of elongated cells, all the remainder being composed of similar round sarcoma-like cells, giving the microscopic appearance quite a different effect from ordinary rodent ulcer. An exact counterpart of this structure was met with in a multiple adenoma of the sweat-glands of the face; and I should have considered it to be an ulcerated adenoma, had not I found, near the ulcerated margin, a marked reversion to the ordinary type of rodent ulcer. The other aberrant case occurred in a man, aged 63, as an ulcer perforating into the nasal cavity, and it also had an unusually thick border of infiltration. It had existed for twelve or fourteen years and was regarded by Mr. Bickersteth as an undoubted rodent ulcer. Here the cells were like the rete mucosum, the only case in which this was noticed; but, instead of being arranged as in epithelioma, they formed very long straight columns, of only one or two cells deep, penetrating far into the subcutaneous tissue, and perfectly uniform throughout the whole growth. This might be called a tubular epithelioma, if regarded entirely from the histological point of view; but clinically, it could only be spoken of as a rodent ulcer, and, until the minute anatomy of the growth is more clearly recognized than at present, the clinical features have the first claim in establishing a diagnosis.

In the foregoing description of the minute structure observed in a number of cases of rodent ulcer, it has been easy to describe the remarkable variability of the growth, and the different types and characters to be met with; no doubt, it reads as though few cases resembled each other, nor do they entirely, but there is a subtle, almost indescribable, uniformity of type traversing most of these varieties, which enables a practised histologist to at once recognize the nature of the growth under the microscope.

As in all other new growths, every variety of rodent ulcer extends in mutual

relationship with a small-cell infiltration; but whatever interdependence exists is capable of a temporary abrogation; and, quite in conformity with the chronic character of the growth, the small-cell infiltration may develop into normal granulation-tissue over the surface of the sore, and may, for the time, allow cicatrization, although it is invariably followed very shortly by a renewed activity on the part of the epithelial elements, at the margin and base of the growth.

2. *What normal Skin-Elements or other Skin-Growths show a Relationship with Rodent Ulcer?*—Innocent epithelial growths usually closely resemble the tissue in which they grow. For instance, an adenoma of the breast, or a papilloma of the skin, shows the same relationship with the parent-tissue that we observe in the case of innocent connective tissue growths, such as lipoma, exostosis, fibroma, myxoma, etc. In the same way, malignant epithelial tumors are stamped with the nature of the parent-tissue, though on account of their imperfect development, they never attain to the precision of structure met with in the innocent tumors. This resemblance of carcinoma to the organ in which it originates is much more striking than is generally admitted, or even supposed. It is such that the tumor can very frequently be referred to the parent-organ through its structural similarity; and I have met with numerous examples, apart from epithelioma, and cylindrical epithelioma, of cancers of the breast, liver, prostate, kidney, nasal mucous membrane, thyroid body, etc., in which any one could at once recognize their special identity. But the evolution of carcinoma is commonly imperfect; and, in the embryonic stages, no one can gather sufficient information from the appearance presented by the malignant tissue to indicate its identity with the normal tissue. An absolutely embryonic condition of the growth is not likely to pervade the whole tumor, nor to be marked in many consecutive cases; so that, in taking a considerable group of any one class of new growths, we may feel pretty sure that the parent-tissue will be distinctly indicated in some of them, even though the indication may very likely have to be traced through the known structural evolution of that parent-tissue.

It is unfortunate that, amongst all the carcinomata, rodent ulcer shows the least striking resemblance of any of them to a normal tissue, and what resemblance is to be traced is not constant. For instance, while one specimen may show a tubular structure, and be referred to the sweat-glands, another has cells of a character and arrangement which point towards an affinity for hair-follicles. The resemblance in the former case, when present, is marked, but in the latter can only be traced through the character of the cells forming the acini; thus, the marginal layer resembles the columnar cells of the root-sheath more than those of the rete mucosum, while the spindle-shape and whorled arrangement of the intermediate cells may indicate an abortive attempt towards the development of embryonic hair-bulbs. Sebaceous glands being only diverticula from hair-follicles, it seems probable that any cancerous development related specially to them would be a variety of the hair-follicle type of growth. The large fatty pseudo-pearls sometimes met with in rodent ulcer may mean a sebaceous transformation of the central cells of the acini. The only other epithelial tissue of the skin is the epidermis itself, the atypical formation of which is, without question, epithelioma; and that there are cases of epithelioma which have the clinical characters of rodent ulcer, such as chronic growth, rodent ulceration, and absence of glandular infection, every one must admit. At present, such cases are only distinguished from the rest after a microscopical examination; but it is questionable whether the clinical line of demarcation between epithelioma and rodent ulcer

is not more correct than an artificial separation based entirely upon minute structure. I was prepared to rely more upon a relationship between the minute structure of rodent ulcer and some normal skin-element than upon any other point, in determining its origin; but a very careful and impartial examination of these twenty-two cases has led me to the conclusion that, if it can be said to be an atypical formation of any epithelial cutaneous tissue, it must be regarded as being equally associated with all the dermal appendages, and I think that it is. Apart, then, from other considerations, there are some grounds for assuming—though they are less clear than in other varieties of carcinoma—that, on this account, rodent ulcer may be described as a chronic carcinoma of the skin, showing very abortive attempts in its evolution towards the development of the dermal appendages.

Innocent glandular growths in the skin are not of common occurrence. It is not without importance that they are met with, like rodent ulcer, almost exclusively upon the face, with the exception of some sebaceous formations which do not belong to the class of adenoma. My own experience is limited to six examples of solid glandular tumors in the skin; one multiple, occurring all over the face and spreading into the scalp, one near the eyebrow, two on the cheek, one on the nose, and one in the scalp. In only the first could the distinct origin of the growth be traced. The patient was under the care of Mr. Rushton Parker, and he removed a large cluster of tumors from the forehead, together with the skin to which they were attached. In the latter, microscopic tumors were found which clearly showed that the primary changes occurred in the sweat-glands. A young growth consisted of spherical acini of small round cells with bright nuclei and indistinct cell-wall, and a marginal layer of elongated cells. The acini were surrounded by a fairly distinct basement-membrane, and were separated by very little connective tissue. Between them duct-like structures were seen at intervals, lined with cubical epithelium, and also portions of sweat-glands. In older growths, many of the cells had undergone a sort of colloid change, which had quite a clear fatty appearance, but was unaffected by osmic acid. This is the case of adenoma, which has been alluded to as being exactly like the infiltration in one of the cases of rodent ulcer. It strongly confirms the relationship with sweat-gland tissue, which is indicated by the structure of the tubular variety. One at least of the remaining cases of adenoma, a tumor of the cheek of twenty-five years' duration, is certainly based upon similar structure; but the others, which were of more recent growth, consisted of epithelial cells, infiltrating a myxomatous matrix, and reminded one strongly of the familiar adeno-myxoma of the parotid. Whether these adenomas originated in sweat or sebaceous glands I cannot tell, the one from the scalp was certainly thought to be of sebaceous origin; but be this as it may, they are all very much like the deep infiltration of rodent ulcer, which has been referred to as a network of cells in a mucous stroma, so much like, indeed, that, in many parts, one cannot be distinguished from the other.

3. *Has Rodent Ulcer any Special Affinity for, or any Special Tendency to spread in one Skin Structure more than Another?*—Much stress has been laid by all recent writers upon observations intended to determine the mode of growth of rodent ulcer, particularly in reference to its tendency to infiltrate certain epithelial skin structures; and having decided which structure is most commonly affected, they have at once concluded that the primary growth originated in a similar tissue. Thus, one investigator finds that changes are to be observed in surrounding hair-follicles, and concludes from this that rodent ulcer is a carci-

noma of the hair-follicles. Others hold similar opinions, based upon similar grounds, respecting the sebaceous and sweat-glands. But even though rodent ulcer does involve these structures, and it certainly does, the fact really proves nothing as to its origin. An epithelial growth may always implicate neighboring epithelium, and though a primary cancer of a glandular organ often shows a special tendency to convert the epithelium of that organ, yet its normal mode of extension is entirely independent of it; while it is also true that a secondary growth may possess the same influence on the gland-epithelial. The mode of increase throws no light upon the minute origin of rodent ulcer, and, as a matter of fact, when a sufficient number of examples are examined, it soon becomes apparent that the growth, in its extension, constantly involves all the dermal appendages, one as much as another, but not all of them put together one-tenth not one-hundredth part as much as the usual mode of growth in the connective-tissue spaces of the skin, in relationship with a small-cell infiltration. Exactly the same holds good of epithelioma. I have specimens in which it infiltrates sweat and sebaceous glands and hair-follicles; but this does not affect its undoubted origin in connection with the rete mucosum, though it is no unusual thing to find this latter—here admittedly the parent tissue—lying in close proximity to the growth, and yet affected by it in no way, except perhaps by pressure.

4. *The Localization of Rodent Ulcer to the Skin of the Face.*—The disease is probably not entirely localized to the face, but it is a remarkable fact that sores of the same clinical characters elsewhere, have almost, without exception, a genuinely epitheliomatous microscopic structure. The adenomata of the skin appear to be very much limited to the same region, while papilloma, like epithelioma, may be met with anywhere. If we had any reason to believe that the origin of rodent ulcer was connected specially with sebaceous glands, then their luxuriance in the skin of the nose and cheeks, and in the large Meibomian glands of the eyelids, might account for these parts being its favorite sites. But there is no sufficient reason to associate rodent ulcer with sebaceous or Meibomian glands, while the usual adenoma of these situations is probably of sweat-gland origin. However, the localization of rodent ulcer and skin adenomata of the face is, to my mind, the strongest piece of evidence that I have met with in favor of associating the origin of the former with the glands of the skin.

5. *Is it possible to obtain Microscopic Evidence of the Commencement of a Rodent Ulcer?*—Somehow or other, it seems to be taken for granted that the first step in the direction of the formation of a new growth involves only the most minute area of tissue, and that, therefore, a rodent ulcer in the first instance is evolved from a single gland or hair-follicle, and not from an appreciable tract of skin. On the other hand, the areas of irritation, which we are justified in regarding as the source of some other new growths, appear to undergo a malignant transformation over a space much more than microscopic from the first. An ordinary epithelioma, or a sarcoma following injury, might either of them be taken as examples. We are so much in the habit of regarding epithelial developments as budding from germs that it seems only rational to suppose that a carcinoma has budded from some little spot that is diseased, perhaps from only a single cell. But as far as we know it, the first stage of every post-embryonic new growth is a condition of irritation and inflammation; a condition which may remain unaltered for an indefinite length of time, and which, but for some specific influence, might have returned to a normal state, though under this influence it becomes transformed into an innocent or a malignant growth. The primary tract of irritation, however, in both its simple and its transformed conditions

involves an appreciable area of tissue of a size, I have no doubt, large enough to be capable of occasional detection and examination in all the stages of its existence.

The microscopic changes which take place during the transition from subordinate inflammation to independent new growth in a tract of irritated tissue can be only a part, and an insignificant part, too, of the whole story; unless, indeed, the presence of a pathogenic organism were to be revealed, which is perhaps improbable. It is, however, quite worth while working out the steps in the transformation as far as they can be seen with the microscope: and it is at least of much importance to be able to identify them, as far as may be, with the normal processes of inflammation and growth. This much seems to me to be clear, that all post-embryonic new growths have a common origin, of the nature of inflammation; that their subdivision into innocent and malignant tumors depends upon the specific infecting or non-infecting character of the inflammation; and that their mature structure develops entirely under the influence of the tissue first affected, so that the tumor is always an imperfect edition of the parent-tissue. Now it is supposed that, if the skin as a whole suffer a chronic irritation, such as that produced by soot or a clay pipe, in certain people the rete mucosum will take on an independent growth, resulting in an epithelioma; but that if the primary irritation affected only a sweat-gland, hair-follicle, or sebaceous gland, the growth would be a rodent ulcer. That an epithelioma commences in an irritation of a patch of skin or mucous membrane is undoubted; it remains, however, an open question whether rodent ulcer has a more limited origin.

In dealing with specimens of pre-cancerous formation in the skin, it is, of course, impossible to be certain as to the correctness of the diagnosis; but surgeons of large experience not unfrequently excise conditions of warty or other alterations in the skin which have become irritable, because, in their opinion, such a state may go on to the development of a carcinoma. It is very probable that, in such cases, the opinion is often correctly formed, and sometimes it is proved to be so by the earliest cancerous changes having actually commenced. I have had several times the opportunity of examining such portions of skin, and the microscopic changes present in them have been uniform and simple. There is an area of increased vascularity, over which a dense infiltration with inflammatory cells is seen, placed just beneath the epithelium. The latter is thickened, the superficial cells being piled up in warty form. The cells of the rete mucosum are evidently undergoing rapid multiplication, the lower layers being often crowded and sometimes appearing as a mass of nuclei. It seems, at this stage, as though the epithelial cells ceased to be able to pass upwards in normal rotation; and one finds instead that, throughout the area of warty thickening, there are buds of rete mucosum penetrating below what is still easily recognizable as the old line of the basement-membrane into the dense inflammatory infiltration, and then it seems as though the epithelial cells, being really the reproductive layer of the rete mucosum, and being now surrounded by an embryonic tissue, become independent, and henceforward grow with the characters of malignancy.

On only two occasions have I had the opportunity of examining tissue, which, it was supposed, might have become rodent ulcer; both were from the upper eyelid. One case was that of an old lady, in whom a small tract of warty growth appeared upon the upper eyelid, and was removed by Mr. Shadford Walker, because he considered it an early condition of rodent ulcer. It showed exactly the same pre-cancerous changes as have been described as occurring in epithelioma. The other occurred as a small papule on the edge of the upper eyelid of a gentleman

aged 47. It had been coming for years, and I snipped it off, as it was irritating the cornea, without excising a portion of the eyelid. The growth in this case was of the nature of a congenital mole; that is, the lymph-spaces of the connective tissue were full of epithelial-like cells, though he was not aware of its congenital origin. The base remains still in the eyelid, and will be excised and examined if independent growth at any time assert itself. The smallest rodent ulcers that I have examined, and some have been very small, even before ulceration had commenced, have yielded no evidence as to their minute origin, since, in all of them, the growth had gone entirely over to the cancerous stage. Under the head of minute origin, then, I have not much evidence to offer as to the primary changes in rodent ulcer; but what there is points in the direction of its probable origin in the skin as a whole, and does not tend to associate it with any particular dermal appendage.

While one follows with the microscope the visible changes which accompany the first steps in the formation of a new growth, one seeks, and seeks in vain for the presence of a motive power. Whether the excitant is engendered by a chronic irritation of the part, or whether it is only rendered locally active by it under certain constitutional conditions, are questions which remain at present unsolved. But the degree of evolution to which a new formation may attain, must plainly depend, to a large extent, upon the nature of this excitant. The more it resembles the normal stimulus to growth and development, the more perfect and limited will be the development of the new growth, as obtains in a fibroma or a papilloma. The more intense the excitant, the more embryonic and unlimited the growth, as in sarcoma and carcinoma. But if it may be that, in some cases, there are local or constitutional conditions, which can weaken the effect of the excitant, then it seems possible that what would otherwise have been an epithelioma, might become a rodent ulcer. For many reasons, I would have preferred to believe that rodent ulcer was a specific variety of carcinoma, and there is much to be said in favor of its association with the glands of the skin, but I am not at all clear that we have any evidence to show that the carcinoma of any anatomical region is susceptible of specific subdivisions in its origin, although it certainly may attain to very different degrees of evolution. For the subjoined reasons, I incline to regard rodent ulcer as a form of chronic carcinoma of the skin, rather than as a carcinoma of any special dermal appendage.

1. Because its structure varies greatly, and because in normal development the rete Malpighii produces very various epithelial structures.

2. Because there are to be seen appearances in the minute structure of certain rodent ulcers, which resemble some points in the evolution of the several dermal appendages.

3. Because, also, there are points of resemblance between certain rodent ulcers and the innocent epithelial growths of the skin.

4. Because the general arrangement and type of the growth is like a slow-growing epithelioma.

5. Because it passes insensibly into epithelioma.

6. Because its minute origin, so far as it can be surmised, is the same as in epithelioma.—PAUL, *Brit. Med. Journ.*, May 2, 1885.

A LECTURE ON THE TREATMENT ON RINGWORM.

HAVING, in the last lecture of this course, spoken of the origin of this disease of its being caused by the growth, in the skin, of the head of a vegetable fungus,

and of its symptoms. I have now to speak of its treatment. The principle of this treatment is perfectly simple; it consists in applying some substance which kills the fungus, the inflammation and other incidental changes in the skin being of minor importance. This method is, in principle, identical with that employed by gardeners to destroy parasitic fungi infesting plants, and even with that which is used in curing fungus-growth in dead materials, as, for instance, the dry rot of timber. Nevertheless, such are the difficulties of bringing parasiticide substances into actual contact with the ring-worm fungus, especially when it is situated in the hair-follicles, that the cure of this fungus-disease is, in some cases, one of the most difficult problems of practical therapeutics. It might be thought that the same results would be attained by rendering the soil unsuitable for the growth of the fungus, but this method is applicable only in a very limited degree. It is difficult to render the soil unfit for the parasite without destroying its vitality altogether. We can only, in certain cases, set up a special kind of inflammation the products of which are fatal to the fungous growth.

Before speaking of the actual methods of cure, we must for a moment consider a point which should always be thought of in the therapeutics of every disease; namely, what is the natural course of the disease? What happens if it be not treated at all? Is ringworm, for instance, an acute disease, like a specific fever, with a natural progress, acme, and termination? Or is it a disease, such as syphilis, chorea, or chlorosis, which has a long natural period of evolution, but still finally comes to an end of itself? Or is it strictly a chronic disease which has no natural tendency to terminate? Ringworm is certainly not an acute disease; but the question whether it has any natural or spontaneous termination is not so easily answered. The allied disease, favus, may certainly last a lifetime. We had at this hospital, some years ago, a family with favus of the scalp. The mother had acquired the disease when a child, had grown up and married, but was still in middle life, uncured. Her husband never caught the complaint, but her children, as they grew up, successively had it at various ages. Every one is not liable to take this disease; but, when once established, it has no natural tendency to get well, at least when it affects the head.

With ringworm, the case is somewhat different. This is never a lifelong disease, the reason being that the susceptibility to it at different ages is very different. Ringworm of the body may, indeed, occur at any time of life, but ringworm of the head is rarely found except in children. Infants, that is to say, up to three years old, do not very often acquire the disease, and when they do so, are easily cured, and the disease may even, perhaps, in them, die out spontaneously; but the period from four years up to the age of puberty is that of the greatest susceptibility.¹ During this time of life, if once acquired, it easily passes into a chronic condition, and may remain for weeks, months, and even years. The influence of idiosyncrasy is as marked here as in any other of the specific diseases, and consequently some children are more liable to this disease than others, and have it more severely. There may be cases in which the susceptibility may be very slight, and in which, therefore, the disease may die out spontaneously; but this, if it occur, is a very rare event. Generally, the child who is liable to the disease is not liable readily to lose it.

The only process which can be regarded as a natural method of cure, is one which I will now describe. Among many of the cases of ringworm, there are always some in which the accompanying inflammation is severe, and this inflam-

¹ Lately, however, two children, aged 5 and 6, were brought to the hospital, each of whom had had the disease since six months old.

mation may go on to suppuration. Each hair-follicle may be converted into a separate pustule, and there may be also diffuse infiltration of pus through the skin. The affected portion of the skin is swollen, intensely injected, and looks as if it were about to form an abscess; though, if an incision be made, there is found to be no single collection of pus, but rather a general infiltration. The hairs become loose, and either fall out or are easily removed. This condition is called "kerion," and was formerly thought to be a distinct disease, though now known to be only a form of ringworm. It is generally supposed to be the effect of too severe treatment, but it may occur when even the mildest applications are being used, and may, I believe, arise in cases which have not been treated at all. This is, at all events, true of ringworm of the beard or parasitic sycosis, in which deep and extensive suppuration is sometimes observed when no remedies whatever have been used. Now the remarkable fact is that, when the condition of kerion subsides, as it will do spontaneously, the disease at that particular part is cured, and a bald patch left, even though it may be making progress in other parts. Kerion, then, is a spontaneous method of cure, or, in the words of Sydenham, "an effort of nature to get rid of the morbid matter." Independently of this occurrence, the disease may spontaneously exhaust itself as children get older. It is said that at the age of puberty it always dies out. This, I dare say, is true; though, fortunately, I cannot say that I have ever observed a single case through a sufficient number of years to arrive at this conclusion from my own experience. It is, however, quite certain that, at or after fourteen or fifteen, children becomes less liable to the disease, and it is more easily cured.

Let me give you an instance in a family that came under my care more than ten years ago; there were six children, all in good health, when ringworm was introduced into the family. The eldest, a girl aged 17, caught the disease, but was easily cured in less than one month. The second girl, a year or two younger, did not take it. The third child, a boy of 13, took it, but was cured as easily as his elder sister. Next in the family came two girls—twins—at that time ten years old. In them the disease caused copious suppuration, in fact a condition of kerion, and both recovered after a few months. The youngest, a girl of 7, perhaps the healthiest of a very healthy family, took the disease at the same time, and, in spite of identical treatment, suffered from it for two years. All these children were treated, in the first instance, by a very experienced and careful medical man, and all in the same way.

Only last week I came across a similar instance. A boy, aged 9, was brought to me with ringworm, which he had had for five years. Five other children in the family had caught the complaint. One was cured in a fortnight; the others after longer but variable periods. One brother had had it, in a public school, for more than a year. Some of those who recovered were said to have had abscesses in the head, that is, kerion. The inveterate case brought to me was a perfectly healthy and robust boy, and the youngest of the family.

I believe you will often meet with the same experience in families. The elder children, if treated, soon recover: the younger have the disease more severely, but also recover, especially if there be suppuration. One case may, on the other hand, be far more obstinate than the rest, and this will generally be the youngest. There must be some special predisposition in these very obstinate cases, but it is extremely difficult to say on what this depends. It does not, I think, as is sometimes said, depend on a bad state of health. One of the children above mentioned was as healthy and robust a child as I have ever seen; and if any one were to put

forward the proposition that healthy children offer a more suitable soil for the fungus than those who are delicate, it would be very difficult to refute it.

Complexion and thickness of the hair seem to have some slight influence. Coarse, strong hair is less liable to be affected than that which is fine; black hair less than blond. Lately I had two sisters under my care, one fair-haired, the other dark. They have been treated in the same way, and the black-haired child is nearly well, while the other makes but little progress. But you will find many exceptions to this rule, if it be a rule; and in general no important predisposing influence can be traced, except that of age. Even this does not always hold, and it is quite impossible to account for the obstinacy of some inveterate cases. The practical conclusion which should be drawn is this, that the recovery of a considerable number of slight cases under any particular treatment is no proof that this method has any special efficacy beyond all others. On the other hand, we must not attribute the long duration of certain cases to any special fault in the treatment. These views, I may say, whatever their value, have been formed after more than thirteen years' experience in the charge of a hospital department, offering a large number of cases every year.

I will now speak of the treatment which we have to employ, and shall confine my remarks chiefly to ringworm of the head—*tinea tonsurans*—because ringworm of the body is far more easily cured; and, with regard to *favus*, this disease is so rare that it has little practical interest for us. Whatever remedy be employed, there are certain practical measures which should always be adopted.

1. Either shave or cut the hair off. In summer, and if the disease be at all extensive, shaving is better. The operation itself drags out many of the loose hairs, cleans the skin, and accelerates the cure. In winter, and in slight cases, cutting may be sufficient. Throughout the whole period of treatment, keep the hair cut quite short; at least, over the affected parts.

2. Let the head be washed thoroughly with soft soap. This rule has been sometimes objected to, and it has even been said that washing may spread the disease. Of this, however, there is no direct evidence, and it is in itself improbable. It will depend on the special mode of treatment adopted how often this washing has to be repeated.

3. Epilation, or pulling out the diseased hairs with forceps, is a valuable aid to all curative methods. This process was first introduced in Paris for the cure of *favus*, and is very systematically carried out at the St. Louis Hospital, where I carefully studied the cure of parasitic diseases in 1865. The method there used is, or was, to pull out all the hairs, sound or diseased, so as to render a small part of the scalp temporarily quite bald. The treatment is carried out for about half an hour at a time every two or three days. In the early stages of cure, either of *favus* or of *tinea tonsurans*, the hairs come out easily, and the operation gives little pain; but, as the disease progresses towards recovery, and the hairs become more firmly rooted, it is extremely painful. During the operation (and this is a most essential part of the treatment), the surface is kept wet with a solution of corrosive sublimate in water (about one grain to the ounce). In Paris, this operation is carried out by trained male hospital attendants, a class to which we have nothing corresponding; and the difficulty in English practice is to know by whom it shall be done. It is obvious that the medical man cannot generally do it himself, and he must, therefore, instruct the mother or the nurse in the art of epilation. The process is much less painful, and nearly equally efficacious (in ringworm, though not in *favus*), if it be confined to pulling out those hairs which,

being diseased, offer little resistance. This may be called the German method, as practised at Vienna.

With regard to the remedial substances employed, these are nearly all what we call parasiticide; but, in fact, most of them have been employed empirically for centuries. Before the existence of parasitic fungi was dreamt of, Bateman tells us that the ancients used sulphur, *atramentum sutorium* or blacking (that is, sulphate of iron), tar, soap, resin, vinegar, and other substances still in use. In the last century, tar and sulphur were generally used. The St. Thomas's Hospital Pharmacopœia in 1741 contained an ointment used for "scald-head," composed of tar-ointment and train-oil in equal parts. The St. Bartholomew's Pharmacopœia in 1739 has an ointment specially intended for tinea, and composed of tar, sulphur, and wax, "to be anointed once a day, the head being covered with a hog's bladder." In fact, the remedies of ancient and modern times are very similar, and may, for the most part, be arranged in the following classes: 1, metallic salts, especially those of mercury, but also of iron and copper; 2, sulphur, with which may be placed the more modern sulphurous acid; 3, aromatic and resinous substances, such as tar, oil of cade, creasote, and carbolic acid, and the compound produced by the action of iodine on tar, called Coster's paint; with these may be placed the modern remedy, chrysophanic acid or chrysarobin; 4, strong irritants, vesicants, or stimulants, such as strong acetic acid, cantharides, and croton-oil. The chief novelties in modern times are the introduction of certain chemical remedies, as borax and boracic acid, carbolic acid, and others, and also the use of mercury and copper salts in new forms. These remedies [are dissolved in, or mixed with, certain materials which may be called "vehicles." These are water, glycerin, alcohol, chloroform or ether, fatty substances, and vaseline.

1. *Watery solutions* have only a limited application. We use solutions of borax, of the strength of from ten to thirty grains to the ounce, or of corrosive sublimate, one grain, or less, to the ounce. Sulphurous and acetic acids are also used in watery solution. All these lotions may conveniently have glycerin mixed with them, to prevent their drying up. The disadvantage of water as a vehicle is that it scarcely penetrates the skin at all, and these lotions are therefore useful chiefly for destroying free spores, or portions of fungus which may be scattered about on the surface. A watery solution of iron salt, in the form of ink, is a well-tried domestic remedy, and, no doubt, cures slight cases; so with the copper solution obtained by keeping a copper coin constantly wetted with vinegar. The list of metallic remedies might doubtless be enlarged.

2. *Glycerin* has been largely used in cases of ringworm, but has scarcely more penetrating power than water, and appears to me to be the least useful medium for applying local remedies. It has, however, one advantage; namely, that, in consequence, perhaps, of not being absorbed, it checks the absorption by the skin of poisonous substances, and hence we may use matters which would be injurious if absorbed with greater freedom when dissolved in glycerin than in any other medium. At one time, I used glycerin of carbolic acid a great deal, but have lately almost given it up.

3. *Alcohol*.—The advantage of alcoholic applications (which they share with chloroform and ether solutions) is that they remove much of the greasy matter which covers the skin, and which is always very abundant in ringworm. By so doing, they are thought to render the skin more permeable to the remedial agent; but, considering the hardening effect which alcohol has on all animal tissues, it is difficult to believe that it can favor absorption. Tincture of iodine is an useful alcoholic preparation, and more efficacious than liniment of iodine made with

water. It destroys the fungus so far as it can reach, and also, by causing desquamation of the epidermis, assists the penetration of other remedies. An alcoholic solution of boracic acid has been strongly recommended by my friend, Dr. Cavafy, and, no doubt, it is useful, though I generally employ boracic acid in another form. Alcoholic solutions of tars are largely used by the Germans.

4. *Chloroform* and ether remove fatty matters from the skin much more completely than alcohol, and, since they quickly evaporate, can have little effect in hardening the epidermis. They have, therefore, chloroform especially, been much recommended of late years, and, no doubt, with good reason. I have used a mixture of chloroform and oil of eucalyptus, in equal parts, with great advantage. A chloroform solution of chrysophanic acid is also highly spoken of; but I cannot think that chloroform, as a vehicle, will permanently supersede that of 1 which I shall next speak.

5. *Fats*, or especially lard, form the main constituent of all the ointments most generally used in the cure of ringworm. Of late years, objections have been brought against the use of any fatty substance for this purpose, on the ground that the skin is already loaded with natural fat, even to excess; but I cannot think that these objections outweigh the universal testimony to the usefulness of ointments in most affections of the skin. There is no doubt that fat, especially animal fat, penetrates the skin more thoroughly than any other medium that we can use. In so doing, it carries with it the parasiticide remedy, and brings it into contact with the fungus at considerable depths below the surface. No fact is more clearly proved than that remedial substances are thus carried by fat into the skin, and diffuse into the body generally. If, for instance, we want to get mercury absorbed for the sake of its constitutional effects, we rub it into the skin along with fat; and the only objection to using mercurial ointments for their local effects is that absorption takes place even too readily. I, therefore, believe that, notwithstanding all theoretical objections, we shall go on using ointments in the treatment of ringworm, at least for a long time to come. Of late years, a preparation of mercury has been brought into use which acts in the same way as an ointment, and has a great penetrating power, namely, oleate of mercury. This substance was first used by Mr. John Marshall, to produce constitutional effects, and is useful, locally, for the very reason that it is easily absorbed. Oleate of copper has been strongly recommended by Dr. Shoemaker. I have given it a trial at the Blackfriars Hospital for Skin Diseases, but find it less powerful than oleate of mercury.

6. Vaseline, paraffin, and similar heavy hydrocarbons have been much used lately as a substitute for lard in making ointments: they have the advantage of being unalterable, but have little penetrating power. Generally speaking, they possess no advantage over lard in the treatment of ringworm.

I will now give the formulæ for the ointments I am most in the habit of using in the treatment of ringworm, but do not claim for these any special efficacy. The same result may be attained by the use of a vast variety of similar mixtures containing the parasiticide substances above mentioned, if properly applied. In fact, we may say of all systems of treatment that the success depends more upon who applies the remedies than upon who prescribes them. Among mercurial substances, we use an ointment containing nitrate of mercury and creasote: \mathcal{R} Ung. hyd. nit. \mathfrak{z} i.; creasoti \mathfrak{m} x.; adipem ad \mathfrak{z} i. M. Another, containing white precipitate and sulphur: \mathcal{R} Ung. hyd. amm. \mathfrak{z} ii.; sulphuris gr. xv.; adipem ad \mathfrak{z} i. M. We also use oleate of mercury. This substance is sold in two strengths, one called five per cent, and the other ten per cent. These names correspond to

the proportions, not of the salt, but of the oxide used in preparing it. The five-per-cent oleate is an oily, semi-fluid substance, the ten-per-cent a rather firm ointment. Carbolic acid may be used in an ointment containing thirty or sixty grains to the ounce of either lard or vaseline. Boracic acid I use in the formula given by Mr. Martindale—paraffin (melting at 135° or 140°) 5, vaseline 15, boracic acid 4 parts.

I have lately employed a remedy which, I believe, has not been used before, namely, eucalyptus-oil, in an ointment made according to Martindale's formula: Paraffin, two ounces; vaseline, two ounces; oil of eucalyptus, one ounce.

I have also employed in a ointment made of lard, in the strength of one drachm to the ounce, and mixed with chloroform, as mentioned above. It is very useful in early cases, and I have seen already several cases cured by it; but it is not among the most powerful remedies.

I will now give you an outline of the course of treatment pursued, first, in a slight or early case, and then in more severe cases. In an early case, after removing the hair, and washing with soft soap (the latter operation should at first be repeated every day), we keep the surface of the head moistened, during the day, from time to time with a lotion; for example, boracis gr. xv., glycerini 3 i., aquæ 3 vij.; M.; or, hydrargyri perchloridi gr. i., glycerini 3 i., aquæ destillatæ 3 vij.; M.; or else, with glycerin of carbolic acid. At night, have one of the ointments above mentioned thoroughly rubbed in, and the head covered with a cap. This treatment, with lotion and ointment alternately, should be continued for two or three weeks, or longer, till the disease has definitely localized itself in particular patches on the scalp. After this, instead of lotions, paint the patches every three or four days with either a tincture of iodine or the remedy called "Coster's paint,"¹ continuing the ointment in the interval as before. By these means, a certain proportion of cases, perhaps one-half, or even two-thirds, will generally be cured in a few weeks, or at most a month or two. Should the case prove more obstinate, or should we have to treat a case where the disease has already existed for some time, we slightly modify the above treatment. In place of the painting with iodine, apply blistering-fluid occasionally, or use "Coster's paint" more frequently. Blisters are dangerous in infants, and should not generally be used in children under five years of age. In such a case, epilation should be very carefully and systematically carried out (taking care to warn the parents of the temporary baldness produced). If these means do not suffice, it will be well to change the ointment and use either a strong preparation of carbolic acid or oleate of mercury. In the circumstances here considered, washing should only be carried out about twice a week.

Should all these measures fail, and the case of ringworm be protracted more than six months, or should we be called upon to treat an inveterate case, an entirely different method is to be recommended. The best plan here will be to apply oleate of mercury, in the five-per-cent strength, by means of a sponge, mop over the whole of the head once a day, without removing that previously applied. The head should be covered with a flannel or linen cap, night and day, and should be washed once a fortnight only, or once a week at most. The result of this treatment usually is, that the skin becomes somewhat inflamed; and there is, at all events, considerable seborrhea, and the scalp becomes covered with scales. It is,

¹ Coster's paint, made according to the original formula (one part of iodine with four parts distilled oil of tar), is a chemical compound, not a mere solution, and contains little free iodine. It is not irritating, and appears to me to be the best of occasional applications; but it need not be used frequently, as it forms a crust.

in consequence, difficult to tell what progress the cure is making. Accordingly, after fourteen days of such treatment, omit the oleate, wash the head thoroughly, and use a milder application, such as boracic-acid ointment, till the skin is clean. We are then in a position to judge how far the disease is eradicated. If broken hairs and stumps still remain, we revert to the oleate treatment, and continue it for another fortnightly period; then clean off the scales as before. A certain amount of suppuration is no reason for stopping the oleate application; but the least soreness of the gums will make us, of course, discontinue it. I must, however, say that I have generally found some constitutional effect produced in those instances in which the oleate has effected a radical cure of the local disease. Cases which have lasted for years may often, by this means, be cured in as many months. I have spoken of some such in the last volume of the hospital reports (*St. Thomas's Hospital Reports*, vol. xiii., p. 325).

If even this treatment fail, there is one yet more severe, namely, the production of artificial suppuration, or kerion. I will not describe this at length, but refer to Dr. Alder Smith's valuable little book on "Ringworm." It is, I think, efficacious, but is very painful and somewhat dangerous. Hence it is, I think, less used than it was a few years ago. With regard to the constitutional treatment of ringworm, I have already said that I think the state of health has little to do with the persistence of the disease. Nevertheless, a change of air, removing the patient from the influences surrounding him at home, often appears to be of great benefit. I should always recommend that, in a very tedious case, the room in which the child sleeps, and the bedding, should be disinfected as carefully as in the case of any other infectious disease. These precautions have in some cases appeared to arrest the disease, which was being treated in vain by local remedies.

With regard to ringworm of the skin (*tinea circinata*), its cure is conducted on the same principles as that of *tinea tonsurans*, but is much easier. The patches should be well painted with tincture of iodine, which is sometimes sufficient. If it should not be, wash thoroughly with soft soap, and apply one of the parasiticide ointments above mentioned. Most cases will be cured in a fortnight.

Ringworm of the beard (*parasitic sycosis*) has become rather more common in London, of late years, than it used to be. It is treated in the same way as other forms of ringworm; but the amount of inflammation is sometimes so great that cooling remedies, especially lead-lotion, have to be used at first. Poultices are better avoided. In the next place, painting with iodine (if the patient do not object) is very useful, both to counteract the deep-lying inflammation and to kill the fungus. In order to effect a cure, carefully eradicate the diseased hairs, and rub in one of the parasiticide ointments. The cure is sometimes tedious, but less so than in a really bad case of ringworm of the scalp.¹—J. F. PAYNE, *Brit. Med. Journ.*, May 23, 1885.

¹ A pure form of oleate of mercury has recently been introduced, which produces no inflammation or seborrhoea. In spite of this advantage, it has seemed, in hospital practice, less efficacious than the impure five-per-cent oleate.

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Original Communications.

THE TREATMENT OF ERYSIPELAS.

BY

DANIEL LEWIS, M.D.,

New York.

THE treatment of what has usually been termed idiopathic facial erysipelas, notwithstanding the numerous specifics which have been recommended, is of interest both on account of the frequency of the disease, and the failure of the usual means to control it, in many cases.

The probable malarial origin of the disease (which is indicated by its prevalence in malarial districts when other diseases of such a nature are unusually frequent) entitles quinine to the leading place as the internal remedy, and in some instances its effect is so marked that the late Dr. Stephen Rogers, Dr. Leroy Satterlee, and others, have termed the use of large doses, combined with the tincture of the chloride of iron, "the abortive treatment of erysipelas." It is doubtless true that in the very beginning of an attack this treatment is often successful, and in the more advanced stages the tonic and antipyretic effects of these remedies are desirable.

But the local symptoms—the relief of the burning pain—limiting the extension of the disease, and thus preventing invasion of important organs—require prompt and constant attention. Before proceeding to recommend the local remedies which have been most useful in my hands, I will

mention the use of the old "lead and opium wash" for the purpose of condemning it as a vile smelling and appearing preparation, the use of which is in every respect disagreeable. I have never had reason to believe that it was any more efficacious than the plain cold water, while the bedding and clothing of the patient would be a little more decent moistened by the clear water. And yet nine-tenths of all cases of facial erysipelas are to-day treated by the use of lead and opium wash.

Dr. A. Jacobi read a paper before the Medical Society of the State of New York at the meeting of 1880 (*Ibid.*, Transactions), recommending the use of a solution of carbolic acid and oleic acid in the proportion of one part to eight. With a gloved hand, eight or ten drops of this mixture were rubbed into the skin *surrounding* the inflamed portion, and the inunction thoroughly done every ten or twelve minutes throughout the day. Such an application has the disadvantage of causing considerable irritation of the healthy skin in many instances, as all who have since used the oleates extensively can testify. If the disease be about the nose and upper lip, the odor of carbolic and oleic acid would be extremely disagreeable to some patients, even though successful, and I believe it should be our aim, as far as possible, to render remedies of all kinds agreeable.

A better remedy in the early stage of the disease is collodion, which was first suggested to me by Dr. Alex Hadden. It is to be kept painted upon as well as around the border of the diseased skin, thus forming an air-tight dressing combined with compression.

This mode of depriving the diseased part of its blood supply has often sufficed to check a well-defined facial erysipelas, even in patients who have frequently suffered from the disease. The applications should be repeated as often as required to preserve the adhesion of the collodion to the entire surface. When any considerable surface is affected, this plan is less satisfactory than white lead paint.

While several American surgeons have mentioned lead paint in these cases, the credit of bringing it prominently before the profession is due to Mr. Richard Barwell, of Charing Cross Hospital, who, in the *Lancet* of March 10, 1883, described what he termed "A Rapidly Successful Treatment of Erysipelas," which consisted in painting the parts thoroughly with white lead paint, dressing the wound, if there be any, by cotton wool saturated with boro-glyceride. The effect was remarkably and quickly successful; cases after operations on the arm for necrosis, and other hospital cases, being well in a few days. The pain was relieved almost at once, and only such after-application needed as to keep the coating perfect. In idiopathic erysipelas, he found it equally successful.

Since the publication of Mr. Barwell's cases, I have used no other local

application for erysipelas, and have often used no internal treatment except the purge as he recommends.

Pure white lead paint of the shops is likely to dry too slowly, and I tell the painter to add some dryer, as in ordinary painting, which in no way changes the effect of the application.

I am unable to give the composition of this dryer, as it is a patent preparation; but painters tell me it is some kind of resin dissolved in linseed oil.

The paint should be thicker than for ordinary use. It peels off readily when desquamation begins, even from the head, where I have often applied it.

The mention of cases in detail seems unnecessary, but several instances of especial interest have been noted. A man whose right ear was completely involved was relieved at once of the burning pain, and recovered without a second application. The same rapid results have been obtained in my practice when the disease involved the nose, face, and various other parts of the body.

Being hastily summoned to a patient who was attacked with facial erysipelas, I found that the disease began thirty-six hours previously, and had rapidly spread over the entire face. The temperature was 103° in the axilla, and the pain was severe. The husband was a painter and had the white lead paint and dryer in the house. It was thoroughly applied over the face, and they were requested to report the condition of the patient on the following day. They failed to do so, and months afterwards, when visiting a patient in the same family, I learned that the single application cured the disease.

Mr. Barwell reports similar rapid results in traumatic cases, and even in hospital cases.

While the application of this remedy gives the patient a somewhat striking appearance at times, when a single ear or the nose is affected, for example, yet it is a dry and cleanly dressing, very easily applied, and as successful as can be desired. It is beyond all question preferable to any means which have been in use up to the present time, and is still entitled to its designation as a rapidly successful treatment of erysipelas.

MYOMA.

BY

ETIENNE C. VIDAL, M.D.,

Attending Surgeon to New York Dispensary for Skin Diseases.

SYNONYMS.—Myoma cutis, Fibromyoma, Liomyoma cutis (λεῖος, smooth), Myoma telangiectasia.

HISTORY.—In discussing this affection, we are, because of its so rare appearance, limited to the information derived from the observations of the few authorities who have had the good fortune to witness it. It is possible, however, that this poverty of the science in respect to it is due, in a great measure, to it having been confounded with other cutaneous diseases of a similar benign nature, especially molluscum fibrosum, and not to the fact that it so seldom exists.

Virchow, in 1854, was the first to employ the term *myoma*, and to describe, histologically, this disease as a cutaneous affection, under the title of *myoma telangiectodes*.¹ Nine years later, 1863, he says of myoma of the skin: "The external tegument presents hyperplasia of muscular fibres in different varieties of tumors: such are the deep verruca, soft verruca, deep nævi (*Virchow's Archiv*, t. vi., p. 552). In these growths, as in lepra (t. 11, p. 517), we often find a considerable hypertrophy of the muscular elements of the skin. However, this hypertrophy exists here, by its nature alone, only as a predominant element of an absolutely different production, and this muscular hypertrophy assumes the form of true tumors only in such places where the cutaneous muscular tissue has normally undergone a high state of development."²

Förster (1858), in describing tumors peculiar to the skin, remarks: "Not only fibroid tumors of the skin may be met with, but also myoma, or, in other words, fibroid tumors containing smooth muscular fibres."³

Verneuil, during the same year, on presenting a specimen to the *Société Anatomique*, stated that it was very difficult to designate this disease, since the term *molluscum*, which had been shown to belong to several different conditions, was not applicable to his case.⁴

In 1863, Förster declared that "molluscoid tumors of the skin, consisting of muscular fibres, were rare."⁵

¹ Virchow: "Ueber Cavernöse Geschwülste u. Telangiectasien." *Archiv für Path. Anat. u. Phys.*, pp. 553, 554, Bd. vi., 1854.

² Besnier, *Annales de Dermatologie et de Syphiligraphie*, 2d.

³ Förster: "Ueber die weichen Warzen u. molluskenartigen Geschwülste der Haut." *Wiener Med. Wochenschrift*, No. 9, 1858.

⁴ *Bull. de la Société Anat.*, 2me Série, xxxiii. Année, Août, 1858, p. 373.

⁵ *Annales de Derm. et Syph.*, 2me Série, tome i., 1880, p. 37.

Besnier, in 1880, contributed the most elaborate and valuable information which we possess upon the subject of dermatomyoma. He says: "Among tumors of the skin, there exist those which are essentially, or principally, constituted by a neoplasia of smooth fibres (muscular histioid tumors). . . . They belong to the class of myoma composed of smooth fibres, leucocellular myoma (Virchow), leiomyoma (λείος, smooth, etc.), (Zenker), liomyoma, according to the present nomenclature."

"Our knowledge of cutaneous liomyoma, or dermatomyoma, as such, is too meagre to allow of an absolute or relative decision as to their frequency; they have been, and are to-day, confounded with different other tumors of the skin, and especially with fibroma (molluscum) and various other benign tumors: but it is nevertheless possible to say very approximately that their frequency is comparable, or slightly inferior, to that of genuine soft fibroma."

DESCRIPTION.—Myoma is a local affection common to both sexes, benign in character; of progressive, but slow growth; appearing in the form of maculæ, or pedicled and sessile tumors of single growth, or disseminated over the tegument, or in groups. They vary in color from a bluish-white, as in Virchow's case, to a pink or deep red; in size, ranging from that of a pin's head to that of the fist or an orange; apparently they are confined to adult and old age, occasioning the patient no alarm, excepting where the tumors have acquired a considerable size; upon removal, there is very little hemorrhage; they may possess, after extirpation, when subjected to excitation, slow and vermicular contractions, similar to those of the scrotum (Challand).²

VARIETIES.—This disease has been divided into two varieties: a simple or true myoma, and a second, which Besnier designates as *myoma dartoïque*.

In the first, the lesion appears upon the trunk and upper extremities, as in Besnier's case. In this patient, a woman, 60 years old, the eruption consisted of lentil-sized, round or irregularly ovoid-shaped maculæ, of very slight pink color, projecting very slightly above the cutaneous surface, "absolutely analogous to the eruption in the papular form of urticaria," presenting also a remarkable analogy to the elements of first appearance of dermato-lymphadenoma (mycosis fungoïde). In addition to these existed little pisiform tumors, simulating the size and form of small shot or pea, rose-colored; the large ones of a dark-red hue; they offered a smooth surface.

In the second and more common variety, the tumors appear singly

¹ Annales de Derm. et Syph., 2me Série, tome i., 1880, p. 44.

² Bull. de la Soc. Anat., Juillet, 1871; 5e Série, tome vi., 46 Année, pp. 145-149.

or multiple, limited to localized regions. This form is clearly exemplified by Virchow's, Förster's, and Challand's cases. In Virchow's patient, a man 32 years old, a small tumor was situated in the neighborhood of the nipple, having made its début thirteen years before. Its march had been slow, and it was succeeded by others of a similar character in the same region; of a similarly slow growth, their number continually augmenting. When seen at the clinic, a dozen of these growths were disseminated over an area of the thorax equal to that of a hand's breadth; most of them were situated beyond the nipple; the largest ones were the size of a cherry; they presented a smooth surface, almost glossy, and were red; the smallest, bluish-white.

In Förster's case, the affection was confined to a clearly defined tumor, suspended by a thin pedicle several lines in length to the scrotum, measuring one and one-half inches in diameter, and covered with a smooth skin.

In the two cases of M. Th. Challand, the lesion appeared in the first, a lady, æt. 25 yrs., upon the superior and external surface of the left labium majus. It had existed for two years, and while at first it remained stationary, it later grew rapidly. Upon removal it was found ovoid in shape, very much elongated, and slightly flattened, offering to the touch the sensation of an empty scrotum. It contained a small, elongated, and hard body.

The second patient, a man 65 yrs. old, offered upon the superior portion of the external surface of the right testicle a pediculated tumor, of green-almond size, with wrinkled surface, of a color similar to that of the scrotum. When pressed between the fingers, it resembled an empty grape-skin. It had, according to the patient, existed forty years.

HISTOLOGICAL CONSIDERATIONS.—The tumors consist of fasciculi of smooth muscular fibres; vascular loops of such dense plexuses as to simulate erectile tumors; large ramifying nervous branches; sudoriparous and sebaceous glands. In Besnier's case, fat-lobules were discovered in the deepest portions of the tumor. In referring to these and the situation of the sudoriparous glands upon the lateral and most profound portions of the growth, he says: "The situation of the lobules and the sudoriparous glomerules, with respect to the muscular tumor, clearly demonstrates that the smooth fibres are developed in the derm, invading principally the median and deep strata."

COURSE.—The course of myoma of the skin is exceedingly slow, as indicated in Virchow's patient, where the tumor acquired the size of a cherry in *thirteen* years, and in that of Challand, where, after a growth of *forty* years, it was no larger than a green almond.

SYMPTOMS.—These are entirely of an objective and negative character, since the disease produces no perceptible disturbance to the general econ-

omy. There is no pruritus; no sensibility upon pressure, excepting when exerted upon the larger growths. Pain, it may be said, never appears spontaneously, since the only case in which it has been present was that of Virchow, where it was so severe as to simulate the "*tubercula dolorosa*."

ETIOLOGY.—The existence of this affection is dependent upon no known cause, since it appears entirely independent of any internal or external morbid condition.

DIAGNOSIS.—This is negative. While it is possible to confound dermatomyoma with other benign cutaneous diseases, a histological examination of the product will reveal its true nature. This is especially the case when there is question of *molluscum fibrosum*, for which our affection is most liable to be mistaken. The pain developed by pressure upon some of the growths may give origin to the supposition that we have to do with neuroma. But these latter are *subcutaneous*, while in the cases cited we find this present in none excepting that of Verneuil, in which case some *few* only were sub-dermic.

PROGNOSIS.—As the affection has apparently no deleterious effect upon the system, the prognosis may be predicated as favorable.

TREATMENT.—This is confined to the cutaneous surface. In cases where the growth consists of isolated tumors, it proves susceptible of cure by enucleation, or removal by means of the *écraseur* or ligature. In Virchow's case, the application of muriatic ether was followed by good results.

Correspondence.

Dr. Henry G. Piffard.

DEAR SIR:—Your favor of June 18th to hands in due course. I beg to apologize that stress of business has detained me from replying to the same before. To my regret, I am unable to give you any information on the subject therein referred to, beyond stating that I manufacture chrysophanic acid from Goa powder, and that it answers in every way the tests given in the German Pharmacopœia, second edition, which will be known to you. In short, I am making the article since its first appearance exactly in every way on the same principle, and analysis of each parcel that left my factory has shown the preparation to be at all times the same. Consequently, if the character of the malady to be treated has not altered, or if the malady is not another altogether, I am at a loss to account for the deterioration alluded to.

I am, dear sir, yours truly,

E. MERCK.

DARMSTADT, August 1st, 1855.

[The foregoing is in reply to letter inclosing copy of the Editorial that appeared in the July number of this JOURNAL.—EDS.]

Editors Journal Cutaneous and Venereal Diseases, New York :

Observing with much interest your recent editorial on the apparent deterioration of chrysophanic acid, or chrysarobin, and your invitation to the profession who use this drug in their practice to communicate their experience, with a view to ascertaining whether this has been observed elsewhere than in New York, I write to add my testimony.

When chrysophanic acid was first introduced into dermatological practice as a parasiticide, the success attending its use gave rise to almost as much enthusiasm amongst dermatologists as the discovery of coccoaine did in ophthalmological circles. I used it with much satisfaction in cases which had previously resisted treatment. I found twelve to fifteen grains to the ounce of vaseline sufficiently strong to produce an active dermatitis, and to destroy at one application the *trichophyton*, or other parasite for which it was used; and, indeed, a much weaker preparation was sufficiently strong for most cases, except on the surfaces where the skin is thickest. On one occasion, an ointment containing ten grains to the ounce, applied to the ear of an adult workingman, produced such violent inflammation (closely resembling erysipelas), with such considerable constitutional disturbance as to call for active treatment to abate it; and it lost me the confidence of the patient and the family.

But of late years I have been so disappointed in the results from the use of the drug, finding often, where I had begun with ten grains to the ounce, that it was necessary to increase it to twenty, thirty, and even forty grains, before its application produced any erythematous effect, that I had utterly lost confidence in it, and had nearly discarded its use. I just supposed it, like all other popular remedies, had been adulterated; and I am glad to see, therefore, a movement which is calculated to bring to light the cause of the very evident deterioration of the drug, or the substitution of inert matter or some form of adulteration, and I hope the effect will be to restore to the profession a reliable article; for, in my hands, that which was first put on the market "filled a want long felt" in dermatological therapeutics, and it is a great privation now to have to do without it, after having learned to rely upon it in a large number of cases of skin disease.

In consultation with my colleagues, I find their experience corresponds with my own, and some consider it entirely valueless.

Very respectfully,

F. E. DANIEL.

100 Bois d'Arc Street, Austin, Texas.

Selections.

BOUGIES: THEIR USE AND ABUSE.

THE use of urethral bougies and sounds dates back to the earliest days of surgery. Apparently in those days, stricture not being known, they were used only for pushing back impacted calculi and other foreign bodies which obstructed the outflow of urine. Guaynerius, who wrote in 1440, mentions the use of wax bougies for this purpose.

Ferri, in the middle of the sixteenth century, described various kinds of bougies for breaking down caruncles. But it was not till Hunter, by his writings, directed the attention of surgeons to the permanent obstructions of the urethral passage, that bougies came into general use for dilating purposes. (See Voillemier, "Dictionnaire des Sciences Médicales," vol. x.)

The varieties of bougie which are employed at the present day may be classified thus:

For Diagnostic Purposes.—1, *bougie à boule*, metal or gum-elastic; 2, the urethrometer, designed by Otis.

For Treatment.—1, steel; 2, silver; 3, pewter bougies or sounds; 4, French gum-elastic: *a*, olivaire; *b*, coudée; *c*, bicoudée; 5, English gum-elastic; 6, filiform of gum-elastic, whalebone, or catgut.

For Guide Purposes.—The pilot or guide bougie.

Besides these, we have Lallemande's *porte caustique*, a bougie or catheter for applying nitrate of silver to the deep urethra; also soluble bougies, by means of which medicaments are applied to the urethral surface in a base of gelatin, cacao butter, or wax.

Let us take the consideration of these various varieties in the order in which I have enumerated them, and first we come to the *bougie à boule*. This is made either of gum-elastic or of metal, and is used purely for purposes of diagnosis. The shaft is thin, and terminates in a bulbous head, which may be made cone, pear, olive, or acorn-shaped, the last two varieties being the ones I usually use. The metal bougies have this advantage over the gum-elastic: they are more durable, and can be used possibly with more precision. The soft instruments are, however, more comfortable to the patient.

By the aid of these instruments we are able to determine the exact situation and extent of any strictures, inequality in the mucous membrane, ulcers, or tender and inflamed areas. If we examine an average-sized healthy urethra with one of these *bougies à boule*, whose bulb measures No. 22 of the French scale, we shall find that it will probably pass, without any difficulty or much discomfort to the patient, for about six inches.

Here one usually meets with a slight resistance, but not enough to impede the passage onwards of the instrument into the bladder. Now, if the bougie be gently withdrawn, as the bulb leaves the prostatic urethra two distinct catches may be felt, about half an inch apart; the first not so marked as the second, and sometimes indeed scarcely discernible. These catches are due respectively to the posterior and anterior layers of the triangular ligament. In a healthy urethra, on further withdrawing the bougie, no other obstruction is experienced until one reaches the meatus, where another catch may occur. These three catches then indicate the narrowest parts of the normal urethra.

In examining for stricture, it is well to bear these points in mind, for I have on several occasions seen surgeons—myself included—misled, diagnosing stricture (a pathological condition) when there was none. This is, of course, a serious mistake for the patient, as he is probably subjected to a course of needless, nay, mischievous instrumentation. That this may prove harmful to the patient I firmly believe, by, to use a term of Mr. Savory's, "nursing into existence" a true organic stricture. It is easy for us to comprehend the course of events leading to such a dire event. The passage of the instrument irritating the membranous urethra causes spasm and congestion, followed by inflammation, and this leads in time to a deposition of neoplastic tissue.

In examining, with a view to stricture, my method of procedure, in con-

junction, I believe, with that of my colleagues, is as follows. It is well to be provided with several sizes of searcher, as this special kind of bougie is sometimes named, say Nos. 14, 18, 22, 26, and 30. The patient standing in front of me, with the penis well exposed, I attempt to pass No. 22 through the meatus, but, should I fail, I now take the next size bougie, namely, No. 18, and find that this passes readily for two inches, but no further. No. 14 is now taken, and passed for five and a half or six inches without any resistance. Let us suppose that at this point only a slight impediment is experienced and the instrument passes on into the bladder. On withdrawing it, a distinct catch is felt at six inches, where we found a slight resistance to the introduction. It is clear, then, that we have here an urethra strictured in three places, namely: at the meatus, at two inches from the meatus, in the antescrotal portion of the urethra, and at the junction of the bulbous with the membranous urethra; that is, at the site of the anterior layer of the triangular ligament.

It is a matter now for determination as to what method to employ for the relief, or possible cure, of this condition. If you believe in the doctrine of the American school, as enunciated by Otis, namely: that strictures are curable, you will probably measure the urethra with the urethrometer. Having found the capacity of the individual urethra before you, which, let us say, measures thirty millimeters in circumference, you will proceed to cut the two penile strictures, using probably Otis's dilating urethrotome, passing afterwards *bougie à boule* No. 30 as far as the deep stricture, to make sure that all the constricting fibres have been divided. The third stricture (of our typical case) is not now dealt with, in the hope of its being chiefly, if not entirely spasmodic, and dependent on the two anterior ones.

Should, however, you be a follower of the other school, which says "once a stricture always a stricture," then you will first try gradual interrupted dilatation; and, if this do not succeed, you may have to call to your aid continuous dilatation, or internal urethrotomy.

A point with regard to the use of the *bougie à boule* is, that it, of all kinds of bougies, is apt to set up spasm. This occurs at the spot where the urethra is surrounded by the compressor urethræ muscle. Sometimes the spasm excited is sufficient to prevent the passage of the instrument. Should this occur, take a *bougie à boule* with a tapering point, or pass a small *bougie olivaire* first. You will then, after a minute or two, succeed in passing your "searcher." This also holds good in cases of spasm where you wish to pass a catheter. Here is a case bearing on this point. Not long ago, a distinguished officer in the Army Medical Department consulted my colleague, Mr. Coulson, in reference to cystitis, for which he had sought relief in vain. It was agreed that I should daily wash out and inject his bladder. On the first occasion, a full-sized catheter passed easily into his bladder, the urethra being caught unawares; but on subsequent occasions I was obliged to pass a small *bougie olivaire* before the full-sized catheter would pass. The spasm in this case was distinctly felt by the patient.

I believe that spasm exists in many more cases than surgeons imagine, either associated with organic contraction, inflammation, or congestion, or independent of these, being then reflex in its nature.

It is a matter of common knowledge, that under chloroform, a bougie which before the administration of the narcotic could not be passed, has slipped in easily, muscular spasm being allayed. Again, it has fallen to my lot on more than one occasion to see cases of presumed organic subpubic stricture, accom-

panied by stricture of or near the meatus, vanish after the complete division of the anterior stricture. After the operation for ligature of piles, how often one meets with retention of urine due to reflex spasm! Sir Henry Thompson, speaking of this, says:

"Spasmodic stricture is an exceedingly useful excuse for the failure of instruments. It is a refuge for incompetence. When you cannot pass a catheter, and wish to desist, it is a convenient thing for the operator to say, 'there is spasm.' I do not think that you ought ever to fail in passing an instrument because there is spasm. Spasm may prevent the urine from going outwards. I do not know that it ever prevents the instrument from going in. In most cases it is failure of the hand, not spasm of the urethra."

I agree with Sir Henry that one ought not to fail in passing an instrument because there is spasm, that is, some instrument; but spasm may certainly prevent the passage of a given instrument.

Besides the *bougie à boule*, there is the urethrometer devised by Dr. Otis for purposes of diagnosis. It consists of a small straight canula, of size No. 8 F., terminating in a series of short metallic arms, hinged upon the canula and upon each other. At the distal extremity, where they unite, a fine rod running through the canula is inserted. This rod, which is worked by a screw at the handle of the instrument, when retracted, expands the arms into a bulb-like shape capable of expansion up to forty millimetres. A thin rubber stall drawn over the end of the closed instrument protects the urethra from injury, and prevents the access of the urethral secretions to the interior of the instrument. When introduced into the urethra and expanded up to a point which is recognized by the patient as filling it completely (and yet easily moving backwards and forwards), the index at the handle then shows the normal circumference of the urethra under examination. In withdrawing the instrument, contractions at any point may be exactly measured.

The advantages of this instrument are these. 1. By means of it we can measure the size of the urethra, and ascertain the locality and size of any strictures present without reference to the size of the meatus. 2. It enables the surgeon to complete the examination of several strictures by a single introduction of the instrument, and by reduction of its size, to avoid the pain which usually attends the withdrawal of the *bougie à boule*.

Its disadvantages are, 1. Often a little bleeding accompanies its use. 2. By reason of the bulb being covered by india-rubber, the sensations conveyed to the hands are somewhat masked. To obviate this, Messrs. Mayer and Meltzer are now making, at my suggestion, a urethrometer whose bulb will not be so delicate as in Otis's instrument, and one which I hope to be able to use without the stall.

I now pass on to the consideration of bougies which are useful in the treatment by dilatation, and first and foremost comes the *bougie olivaire*. This has now quite superseded the English gum elastic, and, as a rule, all metal instruments, as there can be no question that its introduction is attended with less discomfort to the patient than that of steel or silver instruments. The characteristics of a good *bougie olivaire* are as follows. It must be soft and pliable, not too bulbous at its extremity, with an easily bendable neck.

Let us suppose that we have before us a case of stricture that we wish to treat in the usual way, namely, by gradual interrupted dilatation. Having found out the number, situations, and sizes of the contractions, either by the urethrometer or *bougie à boule*, should the patient not be lying down, get him to do so; if this be his first experience of instrumentation, you may thereby save him a nasty

fall, should he faint during your manipulation, an occurrence which sometimes takes place. Warm the bougie by passing it two or three times through the hand. This will also have the effect of removing any dust which might be on it. (I take it for granted that, if the bougie have been used before, it has been well cleaned.) The cleanliness of all instruments which are introduced into the urethra is a matter of the utmost importance. Who will say that, where cystitis and urethral pyemia follow the introduction of instruments, this may not sometimes have been due to impurities introduced on or through them?

Whilst passing the bougie through the hand as suggested, give it a slight curve. I have known this curve to make all the difference between success and failure.

As to the size of the bougie; one, two or three sizes smaller than the capacity of the smallest stricture should be selected; that is, if the patient have several. This is passed gently, and removed after a minute or two; we may then succeed in passing one larger than the estimated size of the stricture. Let us imagine that, in this case, the size of the smallest of the strictures is 14 millimetres. The first bougie passed is 12, followed by 15. In two or three days, the patient comes again, saying that he has passed urine in a larger stream. On this occasion, we commence with 13 or 14 (a size or two smaller than the bougie last introduced); 16 will now probably pass easily, and so on at each successive visit until the stricture has been dilated to the size thought requisite, usually No. 22, equal in size to 12 English, or rather more; though, in some cases of capacious urethræ, it is necessary to continue dilatation to 25 or 30. The next step is to teach the patient to pass a bougie himself, and to insist on his passing it once a week regularly. It is better, perhaps, to name a day on which this is to be done. Should the patient neglect the regular use of the bougie, recontraction will almost inevitably take place. I do not believe that any organic stricture, the same being situated outside and around the mucous membrane, is to be cured in this way. If it be capable of cure, it can only be by complete division of the neoplastic tissue, which is to be effected by urethrotomy.

All cases must not be expected to go as smoothly as this. The urethra may become inflamed and irritable; if so, other means must be employed to calm the urethra before again having recourse to the bougie. A patient's food and drink, as also the weather, may make a difference in what is known as the temper of a stricture. In the majority of cases of stricture of large calibre, with care and trouble, one succeeds in so dilating a stricture that a patient will get on very comfortably, passing a bougie for himself at stated intervals.

There remain, however, a good many cases where the dilating process is not attended with success, owing to the resiliency or what not of the stricture; for such cases an operation is necessary. Of the metal bougies or sounds used for dilating purposes, I prefer a pewter one. It is heavy enough to pass in of its own weight. Its point is made on the type of the *bougie olivaire*, being sufficiently bulbous to prevent the catching of the end in the lacuna magna—which, by the by, ought easily to be avoided, whatever instrument is used, if only you recollect its whereabouts—or any other of the urethral-follicles. Its diameter is greater about the curve; the shaft, being smaller, is not so liable to be held by a small meatus; and, lastly, you may give the instrument any curve or shape you may think fit.

One sometimes meets with a case where a curved metal instrument will pass after every form of flexible has failed. Regarding the method to be employed in the introduction of curved metal instruments, as to whether one should practise

the *tour de maitre*, or pass the instrument straight in, keeping the concavity always pointing towards the pubes, seems to me to be of as small importance as the standing on the right or left of the patient. A dexterous surgeon ought to be able to pass an instrument either way and from either side. Certain it is, that several times failing with the *tour de maitre* from the left, I have succeeded on trying it from the opposite side. The introduction of the finger into the rectum, or the pressing upon the perinæum with the fingers as a point of support, after the instrument has been introduced as far as the bulbo-membranous urethra, are methods to be resorted to for guiding the point of the bougie through the triangular ligament, where often a slight difficulty occurs.

As to the use of the English gum elastic catheter, I know of only one set of cases where this is useful, and this is where the third lobe of the prostate is enlarged. Pass the catheter down to the seat of obstruction, now withdraw the stylet for one inch, and the point of the instrument will be tilted upwards, thereby enabling the catheter to ride over the protruding gland. The *coudée* and *bicoudée* catheters answer this purpose very well. This is their special function, and for it they were designed.

For the treatment of strictures of small calibre, we have the filiform gum-elastic, whalebone, and catgut bougies. Each of these has its own special and peculiar attributes. For instance, the filiform are made sometimes with a corkscrew-like twist at the end; this you will find most useful, when the stricture is at all tortuous, with its orifice situated eccentrically—that is, to one side or other of the canal. The whalebone bougie is of special use, by virtue of its rigidity, for passing through dense and callous strictures. Its extremity can be bent at will, where it is necessary to direct its point to one side or other in cases of eccentric stricture. The advantages attaching to the catgut are almost all shared by the whalebone, with this one exception—namely, that if a catgut, being passed through a stricture, be left *in situ*, it will swell slightly, thereby dilating the stricture more rapidly than can be accomplished by the other varieties.

Long catgut and whalebone bougies are also used in the railroad or tunnelled catheter—an English gum-elastic catheter, open at both ends; the catgut, having been passed through the stricture into the bladder, acts as a guide for the passage of the catheter, which is pushed on over the bougie.

The filiform bougie is often used as a guide or pilot, being, in these cases, screwed on to either a catheter, urethrotome, or some dilating instrument, as Harrison's. With several varieties of the filiform bougie, one rarely comes across a case of impassable stricture; at least such has been my experience in many hundred cases of stricture. Syme used to dwell with force on the fact, in which all surgeons of much experience in urinary diseases concur, "that there are really very few strictures which are impassable, if only the surgeon be dexterous and patient." I need not point out to you that this dexterity is only to be acquired by constant practice. If Syme taught this in his day, how much more ought it to hold good in ours, seeing how much better instruments are at our disposal!

In cases where one or more false passages accompany a stricture of small calibre, and it is desired to get a bougie into the bladder, a good method of procedure is as follows.

Suppose you pass a filiform, and you feel that it has left the urethra, and entered a false passage (this may be indicated by the grating or creaking sensation conveyed to the hand), leave it there; it will block up this road at all events.

Now, pass another; should this likewise pass into a false passage, take a third; and, should there be no more false passages for it to go into, it must per force enter the orifice of the stricture.

You will find that injection of the urethra by oil is a useful adjunct when endeavoring to pass a filiform bougie through a tight stricture; and, better still, is the plan of getting the patient to pass a few drops of urine at the time of manipulation.

I must just say a few words on the treatment of stricture by continuous dilatation—that is, the leaving in of a bougie or catheter for a lengthened period. I must own that I am no friend to this method of treatment, believing it to be more fraught with danger to the patient than internal urethrotomy. Neither do I hold with the practice of tying in a catheter after the operation of internal urethrotomy. The irritating presence of an instrument in the urethra will almost certainly set up an inflammation of both the urethra and bladder; and we may congratulate ourselves if our patient escaped with nothing worse, in the way of urethral fever, leading to suppression of urine and death. Perineal abscess, extravasation of urine, and orchitis, are other local complications. Any or all of these may succeed the mere passage of a bougie; but they are certainly more likely to occur in the treatment of stricture by continuous dilatation.

In conclusion, I will formulate a few rules which may be of service in using a bougie or catheter; firstly, as to what ought to be avoided.

1. Avoid being misled as to the presence of stricture by the deep perineal fascia.

2. Avoid the use of force in introducing an instrument. You will do more harm than good. *Apropos* of this, I will quote you a passage from Mitchell Banks, on diseases of the genito-urinary organs. “The one rock ahead is the desire which the hospital-surgeon (who must operate *coram publico*) has, even in the present day, to get into the bladder at all costs. The unhappy patient being brought into the theatre before a crowd of students, the surgeon considers it a point of honor to get something—if only a No. 1—into the bladder. After twenty minutes’ prodding, with all sorts of instruments, this No. 1 is finally jammed in; the surgeon triumphs, and the patient is led away, bleeding profusely and possibly with a false passage. A week’s rest in bed with hot fomentations to the perineum, would probably so have softened down this patient’s stricture that No. 3 or 4 would have gone in quite easily, to the great facilitating of further treatment.

3. Avoid hemorrhage if possible. Mr. Savory, in the *St. Bartholomew’s Hospital Reports*, “On Spasmodic Stricture of the Urethra,” says: “Whenever blood follows the introduction of an instrument, is it not a sign that, in one respect at least, mischievous force has been employed?” To this I would reply “Not always,” as it is sometimes a necessary part of the cure, as when a patient is suffering from an obstructed urethra, due to a valve, wart, or bridle, the breaking down of which must necessarily be accompanied by a few drops of blood. It is in these cases that cure follows on the use of the bougie alone. I recollect the case of a graduate of Oxford, who came to see me in reference to his stream of urine, which was diminishing in volume, and escaped forked. He had, in addition, pain in the bulbo-membranous urethra, on the passage of an instrument, and slight gleet. After passing a No. 22 *bougie olivaire*, on two occasions, my patient was cured. On each occasion, the passage of the instrument was followed by a drop or two of blood. I imagine that in this case some wart or bridle was broken down.

4. Avoid continuous dilatation—if interrupted is inapplicable to the case, practise, in preference, urethrotomy. Cystitis is caused by continuous dilatation, but cured by internal urethrotomy.

5. Avoid tying in a catheter after internal urethrotomy; pass a bougie on the second or third day.

6. Avoid instrumentation in purely spasmodic strictures.

7. Do not imagine that, because in a given case a so-called full-sized bougie, No. 22 or 25, passes easily through the penile urethra, there can be no stricture sufficient to set up a spasmodic stricture in the deep urethra, or to keep up a gleet.

I would now offer the following advice :

1. Use great care in the introduction of all instruments; see they are smooth, clean, in good condition, and well lubricated, and if of metal, warmed.

2. Always use soft elastic bougies, if possible, and see that the *bougie olivaire* has a pliant neck.

3. More benefit is derived from a bougie which passes easily through a stricture than from a larger one, which is tightly held, and requires force to send it through.

4. It is well, before passing a bougie, to give it a curve, the concavity of which, on introducing it, should look towards the pubes.

5. When using a pilot bougie, always see that the screw is firmly fixed. After the bougie has been used several times, it is apt to become rotten at its junction with the screw. Should this be the case, on withdrawing the instrument through the stricture, the pilot might be left behind in the bladder, necessitating further prolonged operative measures for its removal. I once met with an accident of this kind, the pilot remaining behind in the bladder. I saw the patient two days afterwards, and, after performing internal urethrotomy for a stricture, was able to extract the bougie by means of a lithotrite.—F. SWINFORD EDWARDS, *Brit. Med. Journal*, July 12, 1885.

ON THE CONDITIONS WHICH PRECEDE KELOID, AND ON SOME RARE FORMS OF THAT DISEASE.

It is now, I think, generally admitted that the term keloid should be used exclusively for the disease described by Alibert, and since known as “keloid of scars,” “cicatricial keloid,” and even “false keloid.” That which is known as the keloid of Addison, and even as “true keloid,” has now yielded its claim to the name, and is known as morphea or scleroderma. Thus an important simplification in nomenclature has been secured. I shall accordingly, in the following paper, use the term keloid only, and shall always mean the well-known disease which takes the form of raised glossy scar-like growths flat in the surface and with abrupt irregular margins, from which spurs project into the healthy skin. The commonest place for this disease is in the middle of the chest. Here it assumes its most characteristic type; here it was that Alibert first noticed it, and his beautiful plate shows a patch in this position. The terms “cicatricial keloid” and “keloid of scars” sufficiently denote the general agreement of observers that these patches are generally formed in scar-tissue. So all but universally do we find proof that a scar preceded the keloid; there have been those, and I may confess myself one of them, who have contended that it is always a disease of scar, and never begins in uninjured skin. Those, however, who hold this doctrine the most strongly, are of course very willing to admit that keloid once begun is quite capable of extending far beyond the limits of the orig-

inal scar. They are also obliged to allow that the scar which serves as the mother-tissue may have been very small, such, for instance, as the scar left by a boil. Without this admission, we should encounter a great number of cases in which keloid begins independently of scars. Nor perhaps are the characters of keloid exactly the same, when it begins in a large conspicuous scar, and when it originates in a small and almost hypothetical one. In a very large majority of cases keloid shows a tendency after some years' duration to spontaneous disappearance. The more definitely has the keloid process restricted itself to scar tissue, the more certain it is that spontaneous cure will take place. The common cases in which in children the scars of burns are attacked almost invariably get well, and their duration in many cases is only short. On the contrary, when keloid has begun in a very small scar, and has spread widely at the expense of sound skin, it persists much longer without change, and may possibly last out the patient's life. We know well what the earliest conditions are in the keloid that begins in scars. We have plenty of opportunities of observing in the scars of burns or those of syphilitic rupia that they begin to thicken, and become indurated almost as soon as the wound is healed. Respecting the stages of the cases which begin in very small scars, or as the patient may perhaps assure us, without any, we know much less, for they never come under our observation until the keloid condition is well developed. The case which I am about to relate has important and instructive bearings upon several of the questions to which I have referred. It shows us also the disease in its multiple, and therefore definitely constitutional form; and lastly, it illustrates an event which I never before witnessed, the inflammation and suppuration of the keloid growth itself.

My patient, Mrs. S., was first under my observation about ten years ago, when she consulted me on account of a keloid growth in the middle of her chest which had been present ten years. I told her that she might hope that it would gradually soften, and finally disappear, and advised that it should not be excised. She married, went abroad as a missionary, and I saw nothing more of her until recently. In October, 1884, she returned to England, and came to show me her patch. My prediction that it would soften had been in part fulfilled, but not without grave drawbacks. The upper part of the patch had become quite supple, and almost level with the skin, but at its ends and lower border the disease had spread much, and its borders were very thick and hard. The patch was now four inches long and an inch and a half wide. It ran right across the chest, and was one of the most splendid examples of keloid which I have ever seen. Mrs. S. complained that it itched intolerably, and was often very painful. During the last month it had inflamed in the middle, and an abscess had formed and broken. The formation of this abscess was attended by pain and throbbing, which kept her awake all night. She thought it possible that she had caused it to inflame by scratching and rubbing it. The history of the beginning of this patch was that there had never been any recognized scar. A hardish pimple or sort of blind boil had first been observed. This began to be painful and to itch, and gradually transformed itself into the keloid patch as we see it now. As already stated, it has taken twenty years in reaching its present size, and it is still aggressive at the greater part of its border.

Mrs. S. told me that, in addition to this, the original patch, she had several others, and two which were only just beginning. I examined these with much curiosity. On the right shoulder was a streak of induration two or three inches long, of a bright-red color, and consisting of a series of hard knots imbedded in

the skin. It had been present, I was told, several years, but it had not even yet assumed the characteristic features of common keloid. By this I mean that it had not risen much above the level of the skin, and had not gained its spurs; it was, however, very hard. Just above the navel was another long streak of similar character, but less pronounced. It looked like a scratch from a pin which had inflamed. It had been present a year, and was very hard, but not in the least glossy. The spots which Mrs. S. said were exactly like what the original of the primary patch was in the very beginning, were two small hard papules near to the streak last mentioned, on the abdomen. The papules were conical, about as large as the end of the little finger, and of a dusky-red color. They were not glossy or smooth, but looked much like abortive boils. They had been present, however, nearly a year, so that I have no doubt that Mrs. S. was right when she asserted, from the peculiar itching and pain which attended them, that they were about to become keloid. Near to them was another pustule quite as large, and to the eye one much like them, but this she said was only a little boil which was disappearing, had been present only a fortnight, and had never had any of the peculiar pain of keloid.

It should be added that Mrs. S. had on one thigh the scar of a boil, from which she had suffered some years ago. This scar had never taken on keloid growth. She had no other scars about her. There was no history of cancer in her family, but a cousin had had a cystic tumor in her breast.

We may take the conditions present in this case as examples of the mode in which keloid originates without the intervention of visible scar tissue. Looked at from this point of view, I do not think that we can claim that we can prove that keloid can originate in undamaged skin. From the form of the long streaks, I should feel almost certain that they had really been caused by scratches, and we must note that the condition assumed first is one of chronic inflammation with hardness—not of typical keloid. So also of the two chronic tubercles on the abdomen, they are not at present in the least like keloid, but show only chronic and persisting inflammation. They are like boils which refuse to disappear. Probably by a stage of long persisting inflammation, the tissue is being prepared for the true keloid growth. Good instances in proof that it is rather inflammatory damage than scar, which is the necessary preliminary of keloid, are afforded by the cases in which the lobule of the ear takes on keloid as a consequence of the introduction of ear-rings. It is clear that in such cases the quantity of scar tissue formed can be but very small, and that the chief influence is persisting chronic irritation, like that of a seton. Yet, under such circumstances, I have repeatedly seen the whole lobule become hard and glossy, take on, in fact, the characteristic conditions of keloid.

In an early period of my professional life, having been bitterly disappointed by the recurrence of keloid in the scars of my excisions and, having also repeatedly witnessed its complete disappearance spontaneously when left alone, I made it a rule never to operate. It may be a question, however, whether there are not a few cases which may suitably be allowed to form exception to this rule of practice. That it is a sound one in the great majority of cases I have not the slightest doubt. When, however, we see keloid beginning under exceptional conditions, that is, without any obvious preceding scar, and when it persists for very long periods, and is a cause of great suffering, then I think it may be fair to give the patient the chance afforded by an excision. At any rate, we may admit that our experience is not yet sufficient to make us positive in forbidding it. It may be

that even if the disease should return in the excision-scar, it would be attended by less inconvenience and pain than the original one, and that at any rate time would be gained. It must be admitted with such facts before us as that which I have recorded, that although in most cases spontaneous cure takes place, there are others which are practically permanent. I have not myself, however, for twenty years or more ever excised a really typical example of common keloid. I have operated, however, in two cases which were probably allied to it. They were examples of what has been called subcutaneous keloid, the growth taking place in the corium or even in the subcutaneous tissue, and never tending to cause the raised bossy patch which characterizes the common form. This subcutaneous, or at any rate not cuticular form, is very rare, and its diagnosis from sarcoma of the skin is very difficult. It was with much anxiety in this direction that I was induced in the two cases which I am about to mention, to advise an operation, but in both after operation the microscope showed only fibroid hypertrophy. The cases are sufficiently rare to merit individual record here.

A young woman (aged I think about 19) was transferred to my care by a colleague at the London Hospital, on account of a hard mass in the skin over her left breast. There were, in fact, two indurations close together, and almost joining. The biggest was not larger than a hazelnut, but was more spread out. They were seated in the deeper parts of the skin, and projected a little above the surface, and although quite as hard as keloid, they had not assumed the smooth glossy surface and abrupt margins which characterize it. They had, however, the liability to become painful and to itch intolerably which are so often seen in keloid. On account of these conditions, and because the keloid state was not absolutely marked, I thought it best to excise the portion of skin involved. This was done, and so far as I know, no return took place in the scar. I did not, however, see the patient longer than a year after the operation. The nodules were examined after excision, and found to consist of fibrous tissue.

Another case illustrating the same condition, but on a far larger scale, occurred in the person of a sea captain who was sent to me by Sir Andrew Clark. Again the proper keloid region was the part attacked. The growth was on the front of the chest. It was to the left of the middle line, and the patch involved was three inches long and an inch and a half wide. I possess a colored portrait which well illustrates the appearances presented. They were very different from those of common keloid, for the growth was in the skin, and did not rise above its surface. The hardness was very great, but it was ill-defined, and the patch was more lumpy and thicker in some parts than in others. Where it involved the cutis, which it did in most parts, its surface was pale almost to whiteness, and although smooth not glossy. The patch had been present more than twenty years, and was increasing. It had begun as "a little spot." I excised a large elliptical portion of skin, and it was carefully examined afterwards by several trained microscopists. The conditions were exactly those of the preceding case: dense fibroid thickening of corium.

In this case there had never been any itching or pain, and there was no history of cancer in the family. Captain F. was aged 46, and in excellent health. My notes state that the plate of induration consisted "of a number of flattish lumps welded together," and add that "there were distinct seamy scars crossing it." These features are well shown in the portrait. I have heard from this gentleman recently, and he remains without any indication of recurrence. It is three years since the operation.

Having regard to the very prolonged duration of this growth (23 years), the part in which it began, and its microscopic structure, I think there can be little hesitation in classing it as keloid. Its peculiarity consisted in that it had grown downwards and laterally instead of upwards. Nor, I think, can there be much doubt that the case preceding it was an example of the same disease in an earlier stage. In neither case was there any history of scar, but in both it may be assumed as highly probable that some small scar as of a boil or of acne, preceded the keloid changes.

From what I have already said it will be obvious that I do not believe in the possibility of making a distinction between keloid of scars and true keloid, or rather that I do not believe in any true keloid in the sense of its beginning quite independently of injury to the skin. The reader who is interested in this question will find the facts stated in much detail in Kaposi's able article in *Hebra on Diseases of the Skin*.¹ There is not the slightest doubt that keloid may begin in very small scars, such as those of acne, small-pox, leech bites, and boils. It may even follow a blister if its action has been severe. In these cases the growth once begun does not confine itself to the scar itself, but often advances widely into the adjacent skin. In the exceptional cases in which there is no history of scar, it is impossible with such facts in mind not to suspect that a small one may have been present. We must alter our expression a little, and instead of saying that keloid never begins excepting in scar, say that it never begins excepting in wounded tissue. The mode of recurrence of keloid after excision is of much interest in relation to this subject. It does not recur as cancer does because the adjacent structures have been already infected, but it comes simply in the scars of the wounds made by the surgeon. Its recurrence proves the proneness of the patient to the development of keloid in all scar tissue. Such a patient would be liable to have keloid wherever he was wounded, and quite independently of the primary growth. A case in which I operated many years ago will illustrate this. After excising a round patch of keloid from the shoulder of a girl, I transplanted a flap of skin in such a manner as to prevent all tension. Soon after healing was complete, however, keloid buttons formed in nearly all the little scars left by the sutures.

Although it must, I think, be held that no abrupt line is to be drawn between the cases in which keloid begins in a large conspicuous scar obviously affecting the scar tissue, and those in which it begins in or perhaps around a very small scar, yet it might be convenient for clinical purposes to class the cases separately as varieties. It is probable that the clinical cause of the two differs somewhat. I would even ask that our conception of the keloid process may be yet farther widened. As a rule all keloid patches are peculiar by the absence of tendency to papillary overgrowth. In some cases, however, if I am not mistaken, papillary overgrowth may be followed by keloid induration in the corium beneath. I have seen several cases in which patches which were at first undoubtedly papillary, and which were attended by intense irritation, ended in induration, which was not distinguishable from that of keloid. It was only a few of the patches which were so affected. The case of a lady whom I saw many years ago with Dr. Mennell Williams, at York, well illustrated this. The patches occurred chiefly on the arms, and some of them had become almost smooth and very hard. Cases of multiple keloid are perhaps not very rare. In the instance of a negro who had enormous plates of keloid on his shoulders in consequence of a scald, and whose case I published ten or twelve years ago in the "*London Hospital Reports*," there

¹ See New Sydenham Society's "*Translation*," Vol. iv.

were numerous other smaller patches. In particular I remember that the scars left on his loins, where he had been cupped, many of them formed little keloid masses. Thus it was clear that the constitutional tendency was strong. In the same paper I recorded the details of a case in which the scar of a scald and also innumerable small-pox scars were attacked by keloid. The following are the particulars of this remarkable case, the first of its kind, I believe, on record. The patient was sent to me by Dr. Reygate, of Commercial Road :—

Mrs. O., aged 27, of dark complexion, marked with small-pox rather freely. The first spot of the keloid showed itself “like a little pimple” on the left shoulder; soon after this, another formed on the corresponding part of the right shoulder. This was about twelve years ago, and she was then in good health, but had spat blood in small quantities. Three years later she married, and she has now borne five children. Lately her chest symptoms have increased, and more of the keloid tubercles have also formed. She now has patches as large as crown pieces on the supra-spinous regions; others of varied shapes over the deltoids, a single one on the front of chest, and numerous small ones on the sides of the trunk. They all present the same features—that of raised, glossy, indurated scars. They are very painful, especially at change of weather. The pain begins with itching, and becomes in a little time of a pricking, stabbing character. If she scratches them they prick and burn much more. Sometimes they are not at all painful. On her shoulder near to a patch is seen a thin white scar; this, she says, was left by a scald; she was splashed with boiling water at the age of ten. She thinks that some of the keloid patches formed where she had been scalded; but she is sure that they did not break out until some years after the scald. She is also quite certain that many have now formed on parts where she was never scalded.

There is no history of cancer in her family. The small-pox occurred in childhood. Is it not probable that the multiple manifestation of the disease is, in this case, due to the fact that cicatrices exist in the skin of all parts from small-pox? First, we have it attacking the scars of the scald, which, no doubt, occurred on parts previously scarred by variola; and, secondly, it attacks the variolous scars themselves. Keloid appears to me to be essentially a disease of cicatrix tissue, and I much suspect that it never originates in normal skin. In this instance it was only after the discovery of a small scar that I got the history of the burn; her statement and belief was that the keloid patches had come of themselves.¹

It is an interesting question as to whether there is any relationship of keloid to cancer. We have seen in the case first mentioned that keloid tissue may inflame and suppurate, and I have several times seen it ulcerate. I have no knowledge, however, of any case in which it took on malignant conditions, and caused gland disease; nor was any such mentioned in the report of the Pathological Society's Committee, to which I have referred. In not a few cases of keloid I have obtained the history of cancer having occurred in the patient's near relatives, and in more than one I have seen keloid of a scar coincident with cancer of another part. In the case of a lady who was sent to me by Mr. Moon, of Norwood, a keloid ridge had formed in the scar left after the excision of cancer of breast. The abrupt limitation of the condition to the scar and

¹ A still more remarkable example of keloid in the scars of small-pox with a colored portrait was brought before the Pathological Society in 1881 by Dr. Goodhart, and is published in the “Transactions.” With this case is given a valuable report on the disease by a committee appointed by the Society, of which Dr. Dyce Duckworth, Dr. Pye-Smith, Dr. Goodhart, and myself were members. I am entitled to praise this report because I had very little to do with its preparation.

its special conditions justified me, I think, in regarding this ridge as keloid and not cancer; I quite admit that it is sometimes very difficult to distinguish between the two. Mr. Moon told me that after the wound had healed there was for some time not the slightest hardness of the scar. It was only four months after the operation when I saw the patient. Theoretically, we may quite admit that keloid belongs to the class of new growths which have alliance with cancer, and we may expect that in a few instances such relationship will be proved by the subsequent progress of the case. I may repeat, however, that I have never witnessed such a course of events.

My paper has extended to much greater length than I had intended. It may be for the reader's convenience that I should now briefly state my principal conclusions. They are these—

(1) That with keloid, as with other skin diseases, we must not expect too close a conformity to the type form.

(2) That for clinical convenience we may recognize several varieties of keloid, the prognosis as to spontaneous disappearance and proneness to return after excision differing much in each.

(3) That the first and most typical form is that in which keloid begins in very small, perhaps forgotten scars, and slowly spreads far beyond their limits into sound skin. In most cases the extension and duration are indefinite; and the hardness, glossiness, abruptness of outline, etc., are always well marked. The proneness to recur very quickly after excision is very great in these.

(4) That in the second group, in which keloid growth begins in the middle of large scars, such as those of burns, it is seldom so well characterized. It often does not extend beyond the scar, and often, especially in young persons, soon begins to soften again and to gradually disappear.

(5) That in a third form the keloid growth is deeper, and never produces the glossy, superficial, elevated, and spurred patches which occur in the others. These cases are very slow, and show but little tendency to spontaneous disappearance. They do not develop in connection with large scars, but rather with inflammatory damage to the skin. They are less prone than the others to recur after excision.

(6) That although definite scars almost invariably precede the formation of keloid, yet that there are allied conditions which result rather from inflammation after injury than from anything which is demonstrable as cicatrix.

(7) That the cases of multiple keloid prove either that there is in some persons a remarkable tendency to the disease, or that primary patches have the power of infecting the blood and producing others.

(8) That there is little or no clinical proof of tendency on the part of keloid to pass into cancer.—DR. J. HUTCHINSON, *Med. Times*, May 23, 1885.

XERODERMA AND ICHTHYOSIS.

THESE two diseases, xeroderma and ichthyosis, are but different forms of the same malady; the main features in each are manifested by an increased formation and accumulation of epithelial scales, mixed up with more or less fatty matter and forming branny scales and hard, horny masses.

Xeroderma or dry skin is also called ichthyosis simplex, and this is the most common variety of this affection. Xeroderma is, for the most part, congenital, and its presence is not generally recognized by the parents before the first year or two of life, at which period of life the parents' attention is directed to it in con-

sequence of the harshness and dryness of the skin, and the difficulty they find in keeping certain parts of the skin, such as those covering the elbows and knees, in a cleanly condition. In quite young children, xeroderma only manifests itself by the characters just enumerated and by the tendency of the epidermis to come away in flakes. As life advances, the condition of the skin becomes more marked. The affection is then general, but differs in severity in different parts. In xeroderma the skin presents a peculiar, dry, harsh, ill-nourished and shrivelled appearance, instead of being smooth, elastic, and soft, like normal skin.

This condition of the skin is usually less marked on the palms of the hands and soles of the feet, and also on the inner aspects of the thighs, arms, and wrists. In these parts the condition of the skin appears to differ but little in appearance from healthy skin, except that it is a little dryer. The skin, generally speaking, appears to be ill-nourished, or it seems as if the skin had not been developed so as to keep up to the growth of the other parts. The lines and furrows on the skin are marked out more distinctly than usual, and this is due to the fact that there is less subcutaneous fat present than usual. The face is usually rough, dry, and furfuraceous, but the greater part of the rest of the surface of the limbs and trunk is mapped out into irregular polygonal areas, the limits of which are determined by the normal creases and folds, and the epidermis of these areas is brittle, dry, and hard, separating at the edges, thus giving to this disease an appearance very like that of psoriasis.

The skin looks dirty, the nails are ill-formed, whilst the surface is covered with thin cuticular scales or plates, which are free and loose at their circumference, but attached in their centre. Occasionally the creasings on the trunk are so coarse and deep, and the areas of epidermis between them so large, thick and symmetrical, that the patient's body presents a striking resemblance to that of an alligator.

The aspect of the scalliness varies somewhat; on the neck and trunk this disease presents a scaly appearance, on the head it is mostly furfuraceous, but on the face it is seen in the form of plates. When the scaly condition is well marked the variety is termed *ichthyosis squamosa* or *simplex*, but this is merely a well-marked xeroderma, or, as some authors say, there is no distinct line of demarcation between the conditions termed xeroderma and the mild form of ichthyosis; the difference is only one of degree as regards the epithelial collection. But the places in which ichthyosis is most marked are at the elbows and knees, and those other parts of the surface which have a tendency to get thickened under the influence of pressure and friction. Here the epidermis becomes very much thickened and hard, presenting a black or brown appearance due to impregnation with dirt, and divided even more manifestly than elsewhere into polygonal areas. Wilson states that in this affection many of the sebaceous glands are filled with a dry, hard substance, which often projects from their orifices. A condition of the skin is often met with in chronic wasting diseases, such as phthisis, and is sometimes developed with advancing years. Children suffering from this disease are feeble and emaciated, but this is not a universal rule. They are also often liable to impetigo and eczema.

The skin is functionally disordered in xeroderma; the perspiratory glands do not secrete properly, and hence the dryness of the skin; the sebaceous glands are also affected in their function, and thus give rise to a collection of altered sebaceous matter, and the epithelial scales are present in large plates or horny masses.

This form of disease may show itself shortly after birth, and rarely it may follow a general eczema which has altered the circulation of the skin.

In conclusion, it may be stated that xeroderma is a state of impaired nutrition or atrophy of the skin, characterized by roughness, dryness, and grayish discoloration; the skin is wrinkled and hard, the epidermis is thickened, sometimes desquamating and sometimes collected in crust-like masses. The perspiratory function is impaired; subjective symptoms are wanting.

Xeroderma is congenital and sometimes hereditary, and may vary in degree, and may be considered in its more severe forms as ichthyosis, which is generally accompanied by xeroderma. The term has also been applied by German writers to a rare form of atrophy of the skin with disturbance of pigment and nevoid changes.

Mention may be here made of xeroderma pigmentosum. This name has been applied to this disease by Kaposi. Dr. Radcliffe Crocker, of London, gives to it the name atrophoderma pigmentosum. This disease was first described by Kaposi in Hebra's "Diseases of the Skin," in 1870, and in 1883 he gave a more extended account of it. Early in 1884 Dr. Radcliffe Crocker showed three cases at one of the medical societies of London. These were the first and only cases of the kind known in England, and consisted of two sisters, aged respectively ten and twelve years, and a brother aged nine, out of a family of four. Of English dermatologists, Dr. Colcott Fox is credited as being the first to recognize and fully describe this disease. He says that the cases shown by Dr. Crocker were presented at another society in 1882 as forms of lupus, and that he then recognized the true nature of the affection. So sure was he of the true nature of the disease, that he had a water-color drawing made of the eldest child. He regarded sections of the tumors of these cases as indistinguishable from sections of rodent ulcer. The nature of the early stages of the affection was still open to discussion. Dr. Taylor, of New York, believes the disease primarily to be angioma. Kaposi, Vidal, and Néesser, all believe in an atrophy of the skin in this disease, but there is doubt as to whether this is the primary change.

This disease usually commenced in the first or second year without any apparent cause, affecting the exposed part of the face, neck, and extremities. It spread slowly to the first two or three ribs, also as far as the middle third of the upper arm. In the first stage red blotches or spots appeared, which faded, but left lentiginous pigment spots, or the freckles might be first noticed, which tended to increase in number, size, and depth of color. Presently the skin became very dry, and white atrophic spots appeared between the lentigines, which coalesced into larger areas. The skin in parts peeled off in thin flakes and later became contracted and parchment-like.

Some years after the beginning of the disease, superficial ulcerations, covered with crusts, appeared, and verrucose projections could be felt in the situation of some of the pigment spots. These terminated the second stage.

From the fourth to the sixth year, the third period began. The verrucose projections became the starting-point of fungating epitheliomata. The patient, whose general health had been previously unaffected, became marasmic and died exhausted, or, in a few cases, from the epitheliomatous growths affecting the body generally. Death usually occurred before puberty, but both onset and termination might be deferred. Of the thirty-four cases collated, the number of males and females affected were equal; but a peculiarity of the disease being, that if it affected several members of the same family, it usually limited itself to

the members of one sex only—seven boys being affected in one family, and five girls in another.

Vidal gives an excellent and exhaustive account of this rare disease, of which, up to the time of his description (1882), so far only one or two cases had been met with in Great Britain. Vidal speaks of it as follows: The skin disease which Kaposi has made us acquainted with under the name *xeroderma pigmentosum*, is a disease of families, a disease inborn or congenital, manifesting itself in early life most frequently in several brothers or sisters, affecting almost exclusively children of the same sex—in one family the boys, in another the girls. It develops almost always during the course of the first or second year of life, by the appearance, on those parts of the body which are exposed to light, of red macules surrounded by pigmented spots. The skin then becomes dry, tense, and thin; takes a glistening, cicatricial aspect, and becomes dotted with telangiectases. The epidermis exfoliates in branny scales, becomes rough on other parts, and in course of some years tumors of papillary and vegetating epithelioma appear in various situations. These form most commonly on one or several of the pigmented spots, by preference on the largest and most deeply colored. The epitheliomatous tumors ulcerate, invade large surfaces, and the majority of young patients succumb, between the ages of ten and twenty years, to the progressive generalization of the epithelioma or to marasmus, worn out by the excessive suppuration.

The only disease which, in the early stage, resembles *xeroderma pigmentosum*, is *urticaria pigmentosa*; but here the disease appears by preference on covered parts. Duhring mentions, also, *morphœa* as very closely resembling it; and, indeed, thinks some of the recorded cases should be grouped with *morphœa* or *scleroderma*. Vidal gives a history of five cases, and tabulates thirty-one in all.

The etiology is still *sub judice*. The treatment, whether to arrest or cure the fatal course, had been completely futile. The disease was, *sui generis*, a primary atrophy of the skin, and if the history and all the characters of the disease were carefully considered, *xeroderma pigmentosum* could hardly be mistaken for any other affection.

Ichthyosis may be spoken of as a disease of the skin, which is characterized by the breaking up of the cuticle into polygonal areas, which suggest the idea of the scales of a fish. The surface of the skin is dry, rigid, rough, and grayish in color, and the cuticle exfoliates in fragments, which in one place resemble dust, in others are composed of thin, glistening laminæ like mica. The disease is sometimes congenital, and when not so usually develops early in infancy; it is often hereditary; it is incurable, persists through life, and affects the whole body generally. When the epithelial collections observed in *xeroderma* are exaggerated and marked, the term *ichthyosis* is applied to the disease. The scales in this form of the disease vary in thickness and color, and according to the aspect presented by them in these respects, varieties of *ichthyosis* are spoken of. As regards the varieties, we will find that the disease is most marked on the limbs, and the scales most abundant on the hands and feet, which are dry, horny, and wrinkled, and on the neck and face, where the scaling is dust-like.

The chief varieties are *ichthyosis cornea* or *hystrix*, which is the most exaggerated form of the disease. In this form, together with the papillary hypertrophy and the increased formation of epithelium, considerable sebum gets mixed up in some cases, so that large, dirty masses cake on the skin, and become more or less adherent; these masses being divided up by deep fissures, are best marked

over the knees. These masses also project in the form of spines and lumps. This form is also spoken of as the "porcupine disease."

The least expressed form of the disease is termed *ichthyosis squamosa*, which, as stated previously, is only a well-marked xeroderma. The characters of xeroderma may be well marked over large tracts of the body, and those of ichthyosis cornea localized to particular parts of the same subject. In both ichthyosis hystrix and squamosa, when of long standing, the scales assume a blackish appearance.

Another modification results from the presence of an excess of sebaceous matter, which, by its adhesion to the skin, produces prominent scales, *ichthyosis sebacea*. Where the disease goes on to the formation of spines of considerable length and thickness, it is called *ichthyosis spinosa*.

Ichthyosis nacrée and *ichthyosis nitida* are the forms in which the skin is somewhat thickened, and there is a mother-of-pearl-like polish of the smooth area within the meshes of the lines of motion. When the network of lines which bound the scaly patches are well marked, so as to attract especial attention, the term *ichthyosis reticulata* is applied. When the concretion of the sebaceous and epidermic substance assumes the figure of the scales of reptiles, the term *sauriasis* and *ichthyosis serpentina* are applicable." All kinds of fanciful resemblances have been suggested, such as the terms "serpent skin," "porcupine man," "man fish," and "fish-skin disease."

Anatomical Characters.—In ichthyosis the cuticle is more abundant than natural; the fibrous tissue of the derma is condensed and hard; the cutis of the papillæ is enlarged and elongated; the subcutaneous connective tissue is lax and devoid of fat; the skin appears to lose its elasticity. A well-marked patch of ichthyosis is made up of lamellæ formed by great numbers of flattened-out epidermic cells. These cells are arranged in a striated manner, and undergo fatty change in old cases of the disease. The cuticle formed in excess is hard and brittle, and breaks up into fragments corresponding with the areas of the lines of motion and wrinkles of the skin. These fragments are pulverulent upon the inner side of the limbs, neck, and front of the trunk, angular and prominent in the region of the joints, and smooth, flat, and polyhedral on the internodal parts of the limbs. In ichthyosis cornea the epidermic processes, which are hard, horny, and dry, and are grouped together in an irregular prismatic form and project sometimes half an inch or more above the general surface. They are partly due to an overgrowth of the epidermis in patches, and are largely connected with the horny conversion of the epidermic lining of the sebaceous follicles. The follicles of the skin are filled with dry exuviae and dry sebaceous substances, which in some situations concreted on the surface, and thus increase the thickness of the epidermic crust.

The horny outgrowth first appears as a comedo-like body, which distends the orifice of the follicle and then rises above in a form not unlike a caraway seed. Soon this gets detached, the horny matter still growing upward distends the sebaceous follicle and its orifice until they form a mere shallow pit, which is surrounded by a reddened ring. As the disease advances, the pit becomes effaced, and now what was the inner aspect of the follicle becomes level with the surface of the skin or projects above it, but still continues to produce its horny growth. This tendency to horny development extends from the follicle to the epidermis immediately surrounding it. These bodies become opaque and black, due to the absorption of dirt.

The skin, as a whole, is marked with coarse wrinkles, due to the stiffness and hardness of its substance, and it moves freely on the fascia beneath, owing to the looseness of the subcutaneous tissue. There is also a defect in the oily secretion of the skin, likewise the watery secretion; the skin is devoid of that clearness, lustre, and transparency which is characteristic of healthy skin. In well-marked cases of ichthyosis, the hairs atrophy, and the sebaceous glands are more or less obliterated.

Diagnosis.—When the disease is fully developed, mistakes in the diagnosis are not likely to occur. The congenital nature of the disease, with the dry, harsh, non-perspiratory, scaly, ill-nourished state of the skin, showing the peculiar dark caking upon it, are the chief diagnostic features. Ichthyosis may sometimes be confounded with other affections, such as a simple, harsh, ill-nourished skin, and one affected with chronic universal eczema. The local forms must be distinguished from the warty growths, and also from a form of seborrhea, which closely resembles ichthyosis cornea.

Treatment.—The disease, though incurable, can be greatly relieved. In the first place, the patient must be kept clean and well fed and clothed if possible. If the patient is run down, cod-liver oil and quinine will be useful. Local remedies are the most important. Great benefit will be derived from baths—and the alkaline baths are most useful for removing the scales—but if the disease is obstinate, a strong alkali, applied several times a day, will remove the masses. The lotions may be used warm, if necessary (potash ℥ss. to aqua ℥viij.), and will readily soften the masses. In the horny form of the disease, a clear surface may be obtained by careful soaking of the parts with glycerin, or poulticing, or fomenting. When the hypertrophied masses have been removed by the bathing and washing, their reaccumulation must be prevented by continuing on with this method, or by oil or glycerin inunctions, or tar preparations to check the cell-growth. After the scales have been removed, an alkaline bath used twice or thrice a week containing ℥ij. to ℥iv. of carbonate of soda, or bran, to the usual quantity of water, should be used; after the bath the whole body should be smeared over with some oily substance. The simple form may be benefited by olive oil, neats-foot oil, glycerin and water, glycerin of starch; elder-flower ointment is very serviceable. The oleum theobromæ, or cocoa butter, is one of the best remedies when an oily substance is required.

The principal indications in the treatment are: first, to promote an improved nutrition of the body; second, to remove the epidermic masses and dirt; third, to stimulate the circulation of the skin by inunction and friction. I may add here that the Turkish bath and shampooing will aid greatly the means at our disposal for the removal of the epidermic masses. Mention may be made of ichthyosis of the tongue, which is described by some writers, while others do not recognize it. Dr. Church, of London, has recorded the case of a girl, aged fifteen years, who was affected by the disease on one side of the body, and about the tongue and palate.—KINNIER, *Arch. Ped.*, June 15, 1885.

ANTISEPTIC ATOMIZATIONS IN THE TREATMENT OF ERY-SIPELAS AND EXTENSIVE BURNS.

In a report to the congress held at Seville (April, 1883), on prolonged and continuous atomization as an antiseptic measure, M. Verneil has shown that septic complications in the case of injuries may be advantageously opposed by this

procedure, which neutralizes at once the poison formed in the wound, and allows that which has been already absorbed and has produced symptoms, to be eliminated by the organism.

Among the affections originating in sepsis (including diffuse phlegmon, simple or gangrenous, septicaemia, pyaemia, etc.), erysipelas, being the one least amenable to other antiseptic measures, is also that to which this plan of treatment is pre-eminently adapted—the rapidity and often the wide extent of its invasion giving rise to difficulties that are successfully encountered by the spray, which enables us to follow up the complaint in all its migrations.

Nevertheless, M. Verneuil warns us that the spray is not to be implicitly relied upon as an abortive remedy in every case of erysipelas. “Although,” he says, “I regard this malady as contagious, inoculable, and probably parasitical, yet, knowing as I do, to how great an extent its inception and development are dependent on the patient's constitutional condition, I am unable to believe that any local application whatever can cut short the septic process when once fairly under way. Yet the mode of entrance of the virus from without, and its propagation in the superficial layers of the derma, may warrant us in hoping that at least the local progress of the eruption, when seated on accessible regions of the body, may in this way be moderated; and indeed it would be presumptuous to deny *in toto* the advantages of topical medication in erysipelatos cases, seeing how often they have been extolled by surgeons of eminence.”

The process employed is described as follows: A “pulverisateur à vapeur,” which, as required by its size, may be either held in the hand or deposited on a table, is charged with a one or two-per-cent solution of phenic acid, or with a solution of chloral at the same strength—this last being especially adapted for applications to the face and buccal cavity, as well as for patients who are annoyed by the odor of the acid, or unusually susceptible to its action. M. Verneuil, however, has never known phenic acid, when thus employed, to produce any serious symptoms.

The quantity of fluid ejected is not large enough to wet the patient unnecessarily. If it is wished merely to moisten the wound and the erysipelatos region, the fountain should be placed further off, and the stream directed somewhat obliquely. It is also proper to guard against the patient's catching cold. With this view, he should lie upon the edge of the bed, with only the affected part uncovered, the rest of the body being protected by woollen wraps and a water-proof investment, when possible. The bed clothes can be protected by hoops, as in cases of fractures. The face and eyes may be shielded by curtains or bandages when other regions are being operated on; but the carbolic vapor seems to be perfectly harmless when thrown freely from a one-per-cent solution into the nose, eyes, and mouth, while the face or scalp is undergoing treatment for erysipelas. This fact has led to the prolonged use of the spray, conjointly with that of other agents, in gonorrhœal ophthalmia. When the affected surface is extensive, the vapor is applied to larger or smaller portions of it in succession.

In this procedure, our first object is to disinfect the wound in the most thorough manner possible, by directing the spray into every one of its recesses. When this has been effected, two or three sittings of two or three hours each will be sufficient in the great majority of instances. During the intervals the wound is kept covered with compresses of muslin saturated with a two per cent phenic-acid solution, and overlaid with wadding and india-rubber silk, as in the ordinary antiseptic dressings.

Among the cases related by M. Verneuil is one of an amputation at the upper third of the leg, performed while the affected foot and ankle were laboring under a fully developed erysipelatous inflammation. The patient's constitutional condition being also highly unfavorable, the prognosis, of course, was anything but encouraging, yet under the use of the phenic-acid spray, complete recovery ensued. In all but one of thirteen other cases, the temperature was speedily reduced, and the erysipelas brought under control by the same means.

Equally good results were obtained in the treatment of *burns*, especially when severe and extensive, and when several days, or even weeks had elapsed since their infliction. The spray, in such cases, can be brought to bear against all the breaks and inequalities of the affected surface, thus hastening the detachment of the eschars, and opposing an effectual barrier to the advance of septicæmia.

Antiseptic pulverization will also render us important service when the ordinary Listerian applications are contraindicated or cannot be employed. Thus, in the practice of Prof. Ollier, of Lyons, a man thirty years old was affected, after amputation of the fore-arm, with such profuse and obstinate hemorrhage, recurring upon every disturbance of the dressings, that his life was endangered. In this emergency, the phenic-acid spray was resorted to, and was kept in operation upon the stump for three days continuously, after which it was employed at gradually lengthened intervals until the trouble ceased, and the patient made a good recovery.

Many other illustrative cases are detailed and commented upon, and the conclusions to which they have conducted him are formulated by M. Verneuil, as follows:

"The phenic-acid spray affords an excellent method for the treatment of erysipelas and extensive burns.

"It exerts a powerful antiseptic and analgesic influence. When the locality of the affected region permits, it may be associated with the permanent antiseptic bath.

"In none of the nineteen reported cases can it be said to have produced the slightest unfavorable result. The two deaths which they include were unavoidably caused by the great extent of the lesions. In every other instance, both the duration and the gravity of the complaint were evidently lessened."—*Bulletin Gén. de Thérapeutique*, Feb. 28, 1885.

A NEW ANTISYPHILITIC.

COMPARATIVE experiments with the various subcutaneous remedies recently introduced for the treatment of syphilis have resulted in demonstrating the superiority of Wolff's glycocoll-Hg, considered as a curative agent. Its use, however, is attended with serious disadvantages, arising from its readiness to decompose, the necessity of employing only fresh preparations, its costliness, the severe pain caused by its application, and its occasional production of a bloody diarrhoea. I have, therefore, endeavored to discover some other of the amid-compounds of mercury, which, like the foregoing, should contain a product of the destruction of albumin, but should be cheaper and more readily prepared. The desired substitute, I have reason to think, has been found in a combination of the mercurial salt with urea, the diamid of carbonic acid.

I at first made use of it in a solution consisting of 1.0 sublimate, 100.0 water, 0.22 urea. This was ascertained to be harmless in its action on man, but as the

injections were painful in consequence of containing too small a proportion of urea, the quantity of the latter ingredient was increased to 0.5.

According to a carefully prepared table showing the relative effects of injections with different solutions, and of mercurial inunctions, the latter method is the least rapid in its operation. In this respect the $\text{HgCl}_2 + \text{U}$ solution compares favorably with any other. Its administration is also more easily managed, since it does not require to be freshly prepared on every occasion. 1.0 gm. sublimate is dissolved in 100 ccm. of hot distilled water, to which, when cool, 0.5 gm. urea is added. Such a solution, from chemically pure ingredients, has been in use at my dispensary for more than eight days, without losing its strength or showing any signs of decomposition. Not requiring, therefore, to be renewed daily, like the glycocoll-Hg, the trifling cost of its ingredients makes it a very *inexpensive* preparation.

But the chief recommendation of the $\text{HgCl}_2 + \text{U}$ is the *painlessness* of its application. On this account it is always preferred by patients to either the $\text{HgCl}_2 - \text{NaCl}$ solution or that of glycocoll-Hg, since it causes merely a slight feeling of tension, which disappears in from two to six hours.

Diarrhœa, so far, has never resulted from its operation, while that symptom has been observed in three of my dispensary cases after the use of glycocoll-Hg.

Mercury appears to be more rapidly excreted under the employment of $\text{HgCl}_2 + \text{U}$, the metal having been detected in the urine within twenty-four hours after a *single injection*.

Relapses are no more to be absolutely prevented by this remedy than by the other antisymphilitics. Whether they are any less likely to occur is a question to be determined by future experience.

The frequent and early appearance of stomatitis after injections of $\text{HgCl}_2 + \text{U}$ may be regarded as an additional proof of its speedy elimination by the organism.—JOSEF SCHUTZ, *Deutsche Med. Wochenschr.*, No. 14, April 2, 1885.

URETHRITIS IN THE MALE AND CYSTIC FORMATIONS OF THE PREPUCE.

REFERRING to the exposition of M. A. Guérin, on the formations to which he has given the name of "conduits glanduleux," and which are frequently met with outside the female urethra, although in its immediate neighborhood, Prof. Oedmasson, of Stockholm, announces that he has encountered lesions of this nature in man. He has met with ten cases. In three of these cases these ducts presented themselves upon both sides of the urethra, in the remaining seven only on one side. Ordinarily, they open in the neighborhood of the posterior commissure of the urethra, on the edge even of the lips of the orifice, sometimes more anteriorly, or a little more on the outside of this border. They are situated in the tissues of the urethra, which, when the ducts are inflamed, present sometimes a considerable infiltration. They are generally quite narrow, but they may be a centimetre or more in length. In eight cases the gonorrheal inflammation from which the patients suffered, extended to the duct.

Besides these ducts of the urethra, these sometimes exist others in which the gonorrhœa may localize itself. There are situated between two layers of the prepuce, they open ordinarily upon its interior surface at the attachment of the frænum or immediately above, and they extend in the form of minute subcutaneous cords to the limb of the prepuce or beyond. M. Oedmasson

has observed six such cases. One of them was differentiated from the others, by the fact of the duct opening upon the limb of the prepuce in its middle horizontal line. Another also presented this difference that the duct passed between the two layers of the prepuce and terminated in the glands. The ducts had a length of one to three centimetres, and of sufficient capacity to admit the easy introduction of a moderately sized sound. In five of these cases, the author observed with the urethritis a discharge from the duct, a discharge which ordinarily came on a few days after the urethral discharge, in one case not until the fifth week after. In the sixth case, there was no urethritis, but only a discharge from the duct, which showed itself several days after a suspicious coitus. It could not be considered certain that this patient had gonorrhoea, but in an analogous case observed by Dr. Wilander, after the discovery of the gonococcus, the presence of a number of these bodies was demonstrated in the secretion of the small duct.

These ducts have the appearance of ordinary lymphatic cords, and the author considers it probable that a lymphatic vessel, engorged from some cause or another, had been occluded and had broken an issue through the skin. He gives, as proof of this hypothesis, that at the very point where these ducts are located, there are frequently found small lymphatic cysts, of the size of a pea or of a bean and of a slightly variable form which have generally existed since infancy. The author has demonstrated the presence of these cysts in seven cases, and, in two of them, there existed simultaneously glandular ducts from the urethra.

In the treatment of these different species of ducts in both sexes, the author introduces, when they are not too small, a fine sound covered with a small amount of absorbent cotton dipped in a solution of nitrate of silver, of sublimate, or of tincture of iodine.—E. OEDMASSON, *Nordist Medicinskt Arkiv*, 1885.

BELLADONNA AS A MEANS OF PRODUCING TOLERATION OF IODIDE OF POTASSIUM.

FROM observation of the fact that belladonna produces dryness of the throat, mouth, and nose, Dr. P. Aubert got the idea of employing empirically this agent, in order to combat certain disagreeable effects of iodide of potassium.

In three well-marked cases of naso-pharyngeal intolerance, the administration of belladonna with the iodide gave good results. The same success was obtained in the case of a young man suffering from acute iodism, the symptoms disappeared by preceding the ingestion of the iodide with extract of belladonna. In this case, the dose of belladonna was a pill containing 5 centigrammes given twice a day, night and morning.

In one of these cases, after the belladonna had been continued for several days, it was suspended, and the iodide was still employed without a supervention of the intolerance.—*Journal de Méd. et de Chirurgie*, May, 1885.

AT WHAT EPOCH DOES SYPHILIS BECOME CONSTITUTIONAL?

THE author begins with a critical review of modern experiments concerning the question, whether the initial sclerosis should be regarded as a purely local affection or rather as a symptom of constitutional syphilis, and demonstrates that excision of the diseased part has not as yet furnished decisive results. Even inoculation, and especially auto-inoculation, generally so sure, shows itself here sometimes deceptive, for a result apparently negative may, after some time, give

place to an eruption of the characteristic signs of syphilis. The second inoculation requires a certain period of incubation, and if this inoculation be performed before the initial sclerosis has had time to entirely poison the organism, it happens that the result of the auto-inoculation remains negative at first, but where the period of incubation is completed, it develops a new sclerosis or papules. A large number of experiments undertaken at the Copenhagen Hospital, and five of which are described in detail, prove the justice of the opinion of the author upon this point.—E. PONTOPPIDAN, *Nordist Medicinskt Arkiv*, 1885.

Review.

VORLESUNGEN ÜBER PATHOLOGIE UND THERAPIE DER SYPHILIS. Von PROF. DR. EDUARD LANG, Vorstand der Syphilitisch-Dermatologischen Klinik an der Universität Innsbruck. Wiesbaden: Verlag von J. F. Bergmann, 1884.

We are in receipt of the first two parts of this work, which the author announces will be concluded during the course of the year.

These lectures open with an extended history of the subject, embracing a period which originated with our first knowledge of syphilis, and which terminates with the present. This period has been divided into three parts. First: This begins with our information derived from the earliest Hebrew writers, as indicated in the Bible, and concludes with the epidemic at the close of the fifteenth century. Second, beginning at the year 1495, terminates with the promulgation of the results of Ricord's investigations. These researches at the Hôpital du Midi, which decided the question of gonorrhœa and syphilis as two distinct affections, and the division of this latter into primary, secondary, and tertiary forms, marks the opening of the third period, which is continued to the present day. This first part of the work contains, in addition, lectures upon the initial manifestations of the disease, which are presented in all their various phases, including syphilis vaccinata. Much more space than is usually allotted to the subject has been given to mastitis syphilitica simplex et gummosa. Nearly one-third of Part I. treats of the various species of syphilides, thus affording a complete exposition of each and every variety of this form of manifestation. The second lecture is devoted to the fever of syphilis. Syphilitic vaccination also receives a conscientious review. The part is concluded with the affections, specific, of the hair and nails.

Part II. includes the various organs of the economy as affected by the disease. These the author has discussed in detail, thus embracing the entire organic system. An important part of this volume is consecrated to specific affections of the bones, muscles, tendons, joints, etc. It closes with syphilitic affections of the central and peripheral nervous systems, and the sensory organs.

We would call special attention to the number of exceptionally well-executed woodcuts with which cases are exemplified. It is no exaggeration to say that we have never seen the different lesions so well demonstrated by this class of engraving as is found in our subject of review.

As will be seen, notwithstanding the brevity of our notice, the scope of the

work is extensive, and the author has exhausted the subject. He has treated it with a masterly hand. In diction, it is at the same time choice and comprehensive. In a word, it bears the impress of a scholarly mind, and demonstrates the fact that Prof. Lang is thoroughly versed in his subject.

We can heartily commend the work to the profession at large. But it is the specialist particularly who will appreciate it, and who will find that, although no new theories have been advanced—we refer to the parts under review—it is a very valuable addition to the literature, since the subjects are treated *in extenso*, while other writers have devoted a much more limited space to them.

We can pass no higher encomiums upon it than to express the hope that it will soon be translated into the English language.

In conclusion, we would say that we anticipate with pleasure the appearance of the remainder of the work, and feel assured that it will fulfil our expectations.

Item.

THE AMERICAN DERMATOLOGICAL ASSOCIATION held its ninth annual meeting at the Indian Harbor Hotel, Greenwich, Conn., Aug. 26, 27, and 28; Dr. W. A. Hardaway, President, in the Chair. The following-named members were in attendance: Drs. Alexander, Denslow, Duhring, Fox, Graham, Greenough, Hardaway, Heitzman, Hyde, Morison, Piffard, Robinson, Rohé, Sherwell, Stelwagon, Taylor, Tilden, White, and Wigglesworth.

The following papers were read: Address by the President, Dr. W. A. Hardaway. 1. A Case of Tuberculo-Ulcerative Syphilide of Hereditary Origin, by Dr. J. E. Graham. 2. Clinical Notes on Psoriasis, by Dr. F. B. Greenough. 3. Remarks on a Moot Point in the Etiology of Psoriasis, by Dr. S. Sherwell. 4. Relations of Lupus Vulgaris to Tuberculosis, by Dr. J. N. Hyde. 5. The Treatment of Lupus by Parasitocides, by Dr. J. C. White. 6. Cases of Angioma Pigmentosum et Atrophicum, by Dr. J. C. White. 7. Clinical Notes on Eczema and Psoriasis, by Dr. W. A. Hardaway. 8. Report of Two Unusual Cases of Dysidrosis, by Dr. G. H. Fox. 9. On the Histology of the Vegetable Parasitic Diseases—Tinea Trichophytina, Tinea Favosa, and Tinea Versicolor, by Dr. A. R. Robinson. 10. On the Structure of the Derma and the Development of Elastic Tissue in it, with Demonstrations, by Dr. C. Heitzman. 11. Case of Neuroma of the Skin, by Dr. W. A. Hardaway. 12. Relation of Herpes Gestationis and Certain Other Forms of Disease to Dermatitis Herpetiformis, by Dr. L. A. Duhring. 13. On "Mycosis Fongoide," by Dr. G. H. Tilden. 14. An Unusual Case of Tylosis of the Hands, by Dr. R. B. Morison. 15. Remarks on Electrolysis and Other Practical Topics, by Dr. C. Heitzman. 16. On Syphilitic Re-infection, by Dr. R. W. Taylor. 17. Observations on the Oleates, by Dr. H. W. Stelwagon. 18. The Treatment of Acne by the Use of Sounds in the Urethra, by Dr. L. N. Denslow. 19. A Case of Syphilitic Aphasia and Paraplegia Followed by Death. With an Account of the Autopsy, by Dr. L. N. Denslow.

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EDITORIAL NOTE.

THE appearance of the chromo-lithograph, which was prepared for the October number of this JOURNAL, has been delayed from the failure of the contributor, by reason of sickness, to furnish the descriptive text.

It will appear in the November number.

A CASE OF TUBERCULO-ULCERATIVE SYPHILIDE OF HEREDITARY ORIGIN.¹

BY

J. E. GRAHAM, M.D.,

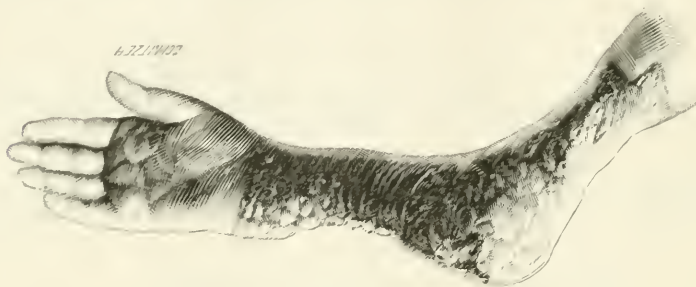
Toronto, Canada.

THE following case, which came under my observation during the winter of 1881, presents in an extensive and striking form a tuberculo-ulcerative syphilide of hereditary origin. I am indebted to Dr. Aikens, of Toronto, for the privilege of examining and noting the progress of the case.

S. J., æt. 16, born in Canada, was first seen by me in February, 1881, when these notes were taken. She enjoyed moderately good health up to the commencement of the present disease. She had never suffered from any severe illness and, so far as known, she never had any previous eruption on the skin, nor has she shown any early manifestation of syphilis. About five years ago, she received a blow from a stick on the right forearm, a short distance above the wrist. The part was not cut, but was bruised. The ecchymosis disappeared in about a week's

¹ Read at the ninth annual meeting of the American Dermatological Association.

time. In a few days after its disappearance, a local swelling commenced which in turn suppurated and discharged matter. The ulcer produced in this way never healed up, but spread very slowly, so that, at the end of the year, two or three ulcerated patches existed instead of one. At the



end of the second year, the disease had extended half-way up the forearm. At the end of the third year, the ulceration had almost reached the elbow. During the fourth it passed over the joint, and now in the fifth year it had extended along the arm nearly half-way up to the shoulder.

Throughout the whole course of the disease, a very imperfect form of



cicatricial tissue has followed the ulcerative process. The integument was not completely destroyed, as many small islands of sound skin remained. The ulceration was in most places very superficial, and in no place was it very deep.

There is no history whatever of acquired syphilis.

Present condition.—Patient is pale and somewhat anæmic, but does not present any of the ordinary features of hereditary syphilis. Her

general health is very fair, and she is moderately well nourished. The right arm presents the following appearance. From the wrist to the elbow there is very little healthy skin, its place being taken by cicatricial tissue; very little secondary ulceration has taken place in the old cicatrix.

The forearm has a hard feel, and presents, on its surface, elevations and depressions, and is covered in places by thin scales. The disease does not seem to extend deeper than the subcutaneous areolar tissue, as she is able to move her hand and grasp with the fingers. The parts over the ulnar are more atrophied than in other parts of the limb. The wrist presents some spots of ulceration, but the disease has not spread to the hand.

The hand is swollen and œdematous, owing to interference with the superficial venous circulation.

The elbow is covered by the same form of tissue as the forearm. The joint is but slightly movable, owing to hardening of the surrounding tissue.

The arm, for about three or four inches above the elbow, is atrophied and covered by the same cicatricial tissue. At the extremity of the cicatrix, there is a ring of ulceration beyond which the skin is healthy. The line of ulceration extends completely around the arm, and is about half an inch in width. It presents a peculiar worm-eaten appearance. The ulcerating process seems to begin in the epidermis, and extends into the deeper structures. This gives the skin a peculiar bevelled appearance. Immediately beyond the ulcerating line, beneath the sound skin, there is a ring of induration. The latter, however, is not very well marked. There was no appearance of nodules such as are found in lupus.

The left clavicle presented about its centre a very marked thickening, and immediately underneath this swelling an ulcer existed in the skin. The latter was about the size of a fifty-cent piece. The sore has a hard, infiltrated edge, and does not show any sign of healing. Both the enlargement and the ulceration were the result of a blow.

None of the sores presented that peculiar copper-colored appearance common in syphilis.

Heart and lungs healthy. The urine normal in character.

Family History.—Her mother is living and healthy. She has three sisters, all older than herself. They are also healthy. I was unable to get any reliable account of her father's illness and death until quite recently. He died when the patient was about eighteen months old, now about seventeen or eighteen years ago. The immediate cause of death was pneumonia, but he was suffering at the time from tertiary ulceration of the throat. On account of the somewhat sudden death, a

coroner's inquest was held, and the fact of his having had syphilis was thoroughly established.

Treatment.—Mild mercurial ointment was applied to the arm. Internally a mixture containing $\frac{1}{4}$ gr. bichloride, 5 grs. potass. iodid. to the dose, with tr. columbo was given.

Under this treatment, the patient steadily improved. The ulceration healed up both on the arm and under the clavicle, and the general health became much better.

The diagnosis in the case was a matter of difficulty. No history of syphilis could be obtained at the time, and the ulceration presented so much the appearance of scrofula that I had put the case down as one of ulcerative scrofuloderma. Dr. Aikin, however, determined to adopt an anti-syphilitic treatment, which, as above shown, was quite successful in curing the patient.

Taking all the facts into consideration, there can be little doubt but that we have here a tuberculo-ulcerative syphilide¹ the result of hereditary disease—a condition which did not develop until the patient was twelve years of age. So far as could be ascertained, there was no sign of the disease during infancy or childhood.

The difficulty of the diagnosis led me to inquire into the literature of the subject, when I was struck with the short description given in some text-books, and its complete omission in others.

In Bumstead and Taylor, under the head of “Tubercular Syphilide of Hereditary Origin,” occurs the following: “This lesion, much rarer in hereditary than in acquired syphilis, may occur as early as the sixth month, or a second attack may be met with several years after birth.” A very clear and succinct description is then given of the disease.

It concludes as follows: “Similar eruptions are also seen in scrofulous children, but the greater surrounding hyperæmia, which is of a bluish rather than a coppery color, in the scrofulous affection, and the points already given in the description of ulceration of acquired syphilis may aid in the diagnosis.”

These authorities speak of a second attack occurring later in life, which indicates that they consider that a first attack always comes on in infancy. In this case there was no history whatever of infantile syphilis. The means of diagnosis above given would also have been quite inadequate in this case, as the ulceration in outward appearance resembled more a scrofuloderma than a syphilide.

In Lancereau's work on “Syphilis,” two cases are reported from Cazenave of two girls, one nine and the other eighteen, in the latter of

¹ I have used the term tuberculo-ulcerative for two or three reasons. The incubation which preceded the ulceration, and the somewhat serpiginous character of the latter, made it resemble that form of syphilide more than any other.

whom the symptom appeared at ten years of age. They had tubercular and serpiginous eruption which had no serious effect. It was impossible to find any primary lesions, the existence of which was now rendered very improbable by the age at which the secondary phenomena had appeared. The first case was cured by the use of the proto-iodide of mercury.

Tilbury Fox is of opinion that many of these later lesions of syphilis are confounded with strumous inflammation. He further states: "I have seen papular, bullous, pustular eruptions, ulcerative and gummatous disease clearly traceable to inherited syphilis, in children of four, five, ten, and even in young persons of seventeen or twenty years of age." He then gives a general description of these latter eruptions, mentioning the tubercular and ulcerative among others.

In Hebra's work, a very clear description is given of the serpiginous tubercular lesion as it occurs in hereditary and acquired syphilis. He speaks of its resemblance to a condition found in Norway, to which their physicians have given the term *Radesgye*.

It would certainly be of great advantage if there existed a classified list of these later skin lesions of hereditary syphilis, together with a clear description of each, such as is given in those resulting from acquired syphilis. Such a work would render the diagnosis of these obscure cases an easier matter than it is at present.

A very important question is raised by the history of this case, viz., that of the tardy development of syphilis. Can such a lesion as has been described appear on a patient at the age of ten or twelve, or even later, who has not had infantile syphilis? This question has been raised again and again, and to judge from the work on skin diseases lately published in connection with Ziemssen's *Encyclopædia*, it is not yet settled.

I can only say for this case that I endeavored in every way to obtain information both from the patient herself and from her mother, as to the previous existence of early symptoms of syphilis, and I could get no history of any such condition.

REMARKS ON A MOOT POINT IN THE ETIOLOGY OF PSORIASIS.¹

BY

SAMUEL SHERWELL, M.D.,
Brooklyn, L. I.

AT various times, in discussions in the New York Dermatological Society having relation to the etiology, etc., of psoriasis, I have been struck by the fact that among some of the members there

¹ Read at the meeting of the American Dermatological Association, August, 1885.

has been a manifest divergence of opinion as to the *ordinary general health* of individuals suffering from this trouble; so marked, indeed, have been some of the expressions of opinion that, to fortify or correct my own convictions on the subject, I have been led, as opportunity offered, to look up the older and indeed most authors as I think of any weight in matters dermatological, to see if I could arrive at anything like a "consensus" of opinion on the subject.

My own belief and experience agree so with Hebra's, to which I need not more than allude to here, that I only prefix it in order to make any prejudices that I may have more manifest. I have tried, however, to be just in the brief abstracts and condensations given below. The French authors, in point of precedence among the continental writers, seem to have the right of line; with the writings of the fathers I shall have nothing to do, as I think we should consider it unnecessary and useless.

French.

Alibert (1825), Rayer (1835), Gibert (1840), Hardy (1860-64), Bazin (1868), are all of accord; perhaps Alibert's conclusions make the best summary. He says, "it ordinarily attacks strong, robust subjects, in whom predominate the bilious and sanguineous temperaments."

Bielt (1828-38) and Cazenave (1868) do not differ essentially from the foregoing; the former, however, insisting upon its occurrence from disturbed mental and emotional states, which it might seem reasonable to believe have a "*post hoc, ergo propter hoc*" basis.

The latter speaks of it as always occurring in those of rheumatic diathesis; neither of them have much to say directly bearing on relative *general health*.

Of course, in all the earlier authors, the ever present clashing and confusion of terminology have been considered; the admixture of terms lepra and psoriasis are easily separable, and it will not be necessary to allude to it again in later parts of this paper.

German.

Fuchs (1840) is non-committal as to general health of patients, but gives a variety of supposed causes, moisture, emotional disturbances, etc., etc.

Gustav Simon (1848)—"All is empty speculation as to cause"—says nothing about average general health.

A. Weyl (Ziemssen's "Handbuch") has nothing to say about general health in a definite way; gives, however, his views of etiology, attributing the disease in question, in a somewhat obscure manner, as being due "to irritation of the nerves distributed to the skin in the tracts affected," which is probably true, but looks somewhat like begging the question.

The remainder of the German authors looked up on the subject—Neumann, Kaposi, Behrend, Lassar, etc., etc.—substantially agree with Hebra's views; Kaposi giving perhaps the most pointed delivery; *sic*: "People who have psoriasis are thoroughly sound, robust, feel perfectly well, and there is no such thing as dyscrasia or diathesis" about them.

English.

It is when we turn to the English authors that we find the most fanciful theories and attempted explanations of causation in this affection.

Daniel Turner (1736), so far as I could find, has little to say beyond the relation of his clinical cases and their treatment; judging by inference from some of his descriptions of treatment of psoriasis inveterata, some of his patients at least, one would suppose, must have had pretty robust constitutions to stand it.

Willan (1809) says little on the point in question, but in psoriatic cases believes he has found rheumatic and scrofulous conditions present.

Bateman (1814), equally non-pronounced, but has seen cases occurring in puerperal states, and others in which melancholia, chlorosis, and arthritic conditions have been present.

Jonathan Greene (1841), non-committal, or non-observant.

Samuel Plumbe (1837) attributes psoriasis in general to mental worry and other causes bringing on general debility; mentions, however, as a fact its occurring for the most part in the upper and best nourished and conditioned classes; he contradicts himself, as to debilitated general health, in foot-note, and at the end of his chapter on the subject speaks of masturbation being a cause, and a frequent one.

Erasmus Wilson gives a list of about twenty diseases and diseased conditions as bearing on, and productive of, this skin affection (Hebra's remarks refuting his assertions are of interest in this connection).

Non-committal as to the direct point of this paper, by inference he attributes this diseased state to the most opposed diatheses—says that four per cent of a certain list of cases given were traced to consumptive stock, etc.

Hunt (1847-71) says very little about general health, but thinks there is constitutional predisposition, which on the whole we think probable.

Neligan (1852) speaks of a suspicious heredity, has a leaning to the scrofulous diathesis as being conducive; mentions its common enough occurrence in strong, healthy, plethoric young persons.

Gaskoin (1875), in a treatise on psoriasis and lepra meant to be exhaustive on this subject, gives a number of theoretic causes, some apparently ridiculous, as sepsis, asthma, etc., etc. Nothing definite as to general health of patients.

Tilbury Fox.—“It occurs,” he says, “most often in subjects between fifteen and thirty, and in those of sanguineous temperaments,” says nothing about general health, except the inference to be drawn from the foregoing.

American.

Piffard (1876) not exact on the point in question, mentions the fact of its occurrence in otherwise healthy persons, believes that the rheumatic diathesis is the great predisposing cause, and that exciting causes are various, that prevention of proper oxidation of tissue is the chief.

Duhring, while giving in quotation some of the various theories of its production, commits himself to none; mentions, however, as simple fact statement, the well-known fact of its common appearance about the time of ordinary most blooming health, as in young adults.

Hyde says it appears indifferently in those of the strongest and weakest constitutions, and in combination with diatheses of the most varied character.

G. H. Fox.—“The majority of psoriatic patients seem as strong and hearty as the average of mortals.”

Bulkley.—“Very many psoriatic patients appear in perfect health, but in most a condition of faulty assimilation can be made out.”

Robinson.—“It occurs equally in chlorotic, tuberculous, and well-nourished, healthy persons.”

This, then, is the brief résumé of expressed opinions of the authors named.

I have tried to spare the Association the deluge that more copious quotation and extracts would necessarily involve.

I have tried to be just, as well as brief, but am inclined to think that the conclusions, taken as a whole, balancing weight of authorities, etc., go to strengthen my expressed convictions as to the general good health of individuals having this skin affection.

I think I may say with safety that about fifteen thousand cases of skin disease have passed under my observation, and while my attention to the point in question has been more direct and careful of late years than formerly, I have always been struck by the high general average of health, to all appearances at least, of the affected persons. I can now only recollect one case of psoriasis in which, from appearance or complaint of the individual, I was led to physical examination for phthisis.

In that case I certainly found lung trouble and evidences of a cavity, but judging from her history of the length and continuance of the symptoms themselves I was not clear then, nor am I now, as to whether it was tubercular in origin, or simply a bronchiectatic dilatation.

In my lectures, it has always been my practice to lay stress upon this point, that of general health, as important and differentially diagnostic in

itself, and when cases of the kind present themselves at my clinics, I am accustomed to dilate upon them somewhat in the following manner, in order to impress and fix what I believe to be a fact in the minds of the students:

“Here, gentlemen, you have a case of psoriasis (pointing out the eruption and its elective seats); note the general robustness of this patient; these folks never die, unless they get run over by a locomotive, or catch double pneumonia,” etc. There is yet time for me to correct myself if I am wrong in so teaching, and I shall be glad if the subject is thought worthy by you to have a decision from the most competent court I am acquainted with.

Some year or two since, I did myself the honor of reading a paper before this body on psoriasis and pseudo-psoriasis of palms, etc., in which I spoke of my belief in the excessive rarity of the first, and the almost certainty of the syphilitic diathesis in the other. I have changed my opinion but little since then; there may be cases of frank palmar psoriasis, but they are very rare, in my opinion. The reason of my present allusion to it now is this, that in my remarks at that time I used as an illustrative parallel the extreme infrequency, to say the least, of the appearance of herpes zoster on the *vola manus*; since then, and showing that nothing is impossible, I have seen a case of this last in that locality (at least I could not otherwise diagnose it), my *first* and *only* one. In these cases of palmar squamous syphilides, I have been frequently struck also by the excellent types they have presented of former perfect health. That diathesis being, however, present, they might be called magnificent ruins.

As to any new points on the etiology of psoriasis, I have nothing to present, not even a new theory, and most authors I find, and as has been shown, avoid or obscure the subject. It seems to me that dermatology in that particular is under obligation to Dr. Piffard. Among the very many good things in his work of 1876, he defines his theory of causation in chapter on rheumides, etc., and gives his reasons for his faith therein, in far better, fuller, and more scientific manner than any other author to my knowledge.

His collocation, where not original, explanation of phenomena, and arrangement, seem to me excellent.

AMERICAN DERMATOLOGICAL ASSOCIATION.

NINTH ANNUAL MEETING, HELD AUGUST 26, 27, AND 28, 1885.

Official Report of the Proceedings by the Secretary.

Wednesday, August 26—Morning Session.

The President, DR. W. A. HARDAWAY, in opening the proceedings, said that, although he had no formal address to make, he felt that all would agree with him that great good had been accomplished in the work for which the Association was established since its preliminary organization ten years ago. It had been fertile for good in furnishing a stimulus to the study of dermatology, and had been especially valuable to those of its members who lived at a distance from the greater medical centres. Although interest in the meetings had at times seemed to flag, he felt that the Association would continue to prosper, and that its success was now assured.

He expressed the pleasure it gave him to once more look upon the faces of the older members, extended a hearty welcome to the new members, and declared the meeting open for its regular scientific work.

The first paper was read by DR. J. E. GRAHAM. It was entitled:

A CASE OF TUBERCULO-ULCERATIVE SYPHILIDE OF HEREDITARY ORIGIN.¹

DISCUSSION.

DR. TAYLOR expressed the belief that it is now generally conceded that syphilis can be communicated to the child by the father without infection of the mother (a view which he was the first to advocate in America), although it had long been rejected by many well-known authors. He thought that the case reported was undoubtedly such a one. He and his colleagues, at Charity Hospital, Blackwell's Island, had made repeated and thorough examinations of mothers who had recently given birth to syphilitic children, without finding the slightest evidence of the existence of the disease in them.

An interesting circumstance brought out by the paper was the absence of early symptoms of the disease in the girl. This is often stated in histories of such cases, but he felt confident that the assertion was not well founded, in view of the ease with which a slight coryza, roseola, or onychia might be overlooked. He believed that there must be some early manifestation of the disease in all cases. Deep ulcerative lesions may develop in such children as early as the age of six months, but they did not do so always. His experience had taught him that, while serious lesions, such as gummata, might develop during the first year of

¹ See page 289.

life, they might also remain away until the age of fourteen or eighteen years.

Another important point illustrated by the case was the effect of traumatism in furnishing a starting-point for the evolution of hereditary syphilitic lesions. He cited the case of a boy suffering from hereditary syphilis, in whom a wound of the leg by a stick had been followed by deep ulceration of specific nature. He thought the arguments advanced in the paper conclusively established the syphilitic nature of the malady. It is often impossible to accurately determine the nature of certain ulcerative processes from a limited number of examinations of the patient, a careful study of the family history and the concomitant symptoms being essential, and in many cases, the results of the internal treatment must be taken into account, in order to reach a satisfactory conclusion.

DR. GREENOUGH said that he had recently seen a striking case which went to establish the truth of the doctrine that the father could infect the child without giving the disease to the mother. It was that of a woman who had given birth to three children in succession, all of whom had died from a pemphigoid syphilitic eruption breaking out a few weeks after birth, the woman herself remaining perfectly healthy as far as he could ascertain, during several years' observation.

DR. HEITZMAN said that, in cases similar to the one reported, which were common, it is often impossible to make a diagnosis between syphilis and scrofula. He had recently seen a young man with an extensive ulceration, ten inches in diameter, in the groin. He had been unable to make a diagnosis at the first interview, and told the patient so. He had never seen him since.

DR. WHITE thought that local treatment alone often cured such lesions as those described by Dr. Graham and illustrated by the photographs shown, and he did not think it safe to base a diagnosis between syphilis and scrofuloderma upon the effect of combined treatment. Diagnosis was, in fact, often a matter of extreme difficulty in such cases, and he had had many patients whose disease he was firmly convinced was syphilis, although unable to advance any valid evidence for his belief. It seemed to him possible for the throat disease in the father of Dr. Graham's patient to have been of a scrofulous nature.

DR. GRAHAM said that the physician who had treated the throat affection had pronounced it syphilitic.

DR. DUHRING also alluded to the great difficulty of making a diagnosis in such cases as that of Dr. Graham. The result of the treatment, however, inclined him to believe the case one of syphilis. He thought the complete cure in so short a time as two months very remarkable. This fact also spoke in favor of the case being one of syphilis rather than scrofula.

DR. HYDE said that since he had written on the subject, he had seen a number of cases of children, born syphilitic, in whom most careful examination of the mothers showed no signs of the disease. These cases, however, had not taught him to go as far as Dr. Taylor, who had spoken of vigorous women bringing forth syphilitic offspring, as almost all the mothers were in delicate health.

He had never seen inherited syphilis develop for the first time in ad-

vanced life, and was unable to believe in the existence of a tardy inherited syphilis.

Alluding to the stress laid in the discussion upon the history of cases, he remarked that the more he saw of the disease, the less importance did he attach to the histories given by patients. The disease was so common that accidental cases were of frequent occurrence. One case came into his thoughts at the moment, in which he was satisfied that an ulcerative lesion on the penis was caused by inoculation from the hand of a syphilitic surgeon during the introduction of a catheter.

Dr. HARDAWAY thought it a poor rule in practice to pin our faith upon the results of treatment. Such lesions as those described in the paper were often cured by local treatment alone; hence the fact that they disappeared under combined internal and external treatment was no proof of their syphilitic nature.

Dr. TAYLOR said that he also did not regard treatment as "la pierre de touche" of diagnosis. A careful study of all three factors—family and clinical history, and the results of treatment—are all of importance.

He did not agree with Dr. Hyde, that mothers (of syphilitic children) in whom no positive evidence of the disease could be found, were generally in delicate health, since he had repeatedly seen robust buxom women bring forth such children. They might wither and become pallid afterwards, of course, but not necessarily from syphilis.

Dr. GRAHAM said that it had been found impossible to make a diagnosis in his case until after treatment.

Dr. GREENOUGH then read a paper entitled

CLINICAL NOTES ON PSORIASIS.

It was based on the observation of 394 cases of the disease, which occurred in a number of about 15,000 of general skin disease, or in the proportion of a little over $2\frac{1}{2}$ per cent. 205 cases were in male subjects, and 188 in female.

The ages of the cases when first seen were:

Under 10 years, . . .	21	From 40 to 50, . . .	42
From 10 to 15, . . .	33	Over 50, . . .	50
“ 15 to 20, . . .	47		
“ 20 to 30, . . .	129		
“ 30 to 40, . . .	72		
			<hr/> 394

In 44 cases the patients were seen during the first attack of the disease. Their ages were:

Under 10 years, . . .	7	From 30 to 40, . . .	6
From 10 to 15, . . .	5	“ 40 to 50, . . .	5
“ 15 to 20, . . .	6	Over 50, . . .	1
“ 20 to 30, . . .	14		

In 107 cases reliable testimony as to their age at the time of the first outbreak of the disease was obtained, and it was:

Under 10 years, . . .	13 cases	From 30 to 40, . . .	13 cases
From 10 to 15, . . .	30 "	" 40 to 50, . . .	5 "
" 15 to 20, . . .	15 "	Over 50, . . .	5 "
" 20 to 30, . . .	26 "		

The 151 cases in which the date of the first attack could be determined, *i. e.*, 44 seen during first attack, and 107 when a reliable report of age at time of first attack could be obtained, gave the following statistics:

Under 10 years, . . .	20 cases	From 30 to 40, . . .	19 cases
From 10 to 15, . . .	35 "	" 40 to 50, . . .	10 "
" 15 to 20, . . .	21 "	Over 50, . . .	6 "
" 20 to 30, . . .	40 "		

From these tables a large proportion of the cases proved to be first attacked by psoriasis between the ages of 10 and 40, which is what would be expected from the investigations of other observers; but the fact that, out of 151 cases, 20 showed symptoms of psoriasis before the age of 10, was not in accordance with previous experience; and that 6 cases should have been exempt from the disease for the first 50 years or more of their life, was still more at variance with preconceived notions. In 97 cases he had been able to get what appeared to be reliable testimony as to the existence or not of an hereditary tendency. In 31 of these, psoriasis probably had attacked some one of the patients' near relations, and in 66 the patients felt quite sure that such was not the case. This would give the proportion of cases where definite knowledge on the subject was shown as proving the existence of an hereditary influence in about one-third of the number of cases.

The instances in which the writer's observation had confirmed the generally accepted ideas on the subject were referred to, and cases in which he had found difficulty in diagnosis were reported, as was also his experience in treatment.

DISCUSSION.

DR. HYDE, having been told that none of Dr. Greenough's cases had the eruption on the palms of the hands, said that he himself had never seen a case in which the eruption existed on these parts alone. He had seen cases on bald heads, where the patches showed a decided preference for the still hairy portions, never extending more than half an inch beyond the limits of the hair. Itching was, in his experience, often one of the most distressing symptoms of the affection. He had also often observed that the patches were quite as well developed over the sacrum as on the extensor surfaces.

DR. DUHRING alluded to the omission of the reader of the paper to make any mention of the difficulty often met with in making a differential diagnosis between seborrhœa capitis and psoriasis confined to the scalp. In cases of young girls, he himself often found great trouble in making the diagnosis; and several cases which he pronounced to be seborrhœa had afterwards proved to be psoriasis.

DR. ROBINSON said that, although he agreed with nearly all the statements made by the author of the paper, he would take exception to one or two. He thought that a diagnosis between psoriasis of the scalp and favus was not difficult. When a favus crust is removed, the surface is, as a rule, found to be shiny and depressed, not raw and granular, as was stated in the paper. The latter condition was encountered only in the later stages of favus.

He thought that Dr. Greenough was right when he stated that psoriasis begins as a small rose-colored non-scaly spot. Auspitz taught that psoriasis is primarily an affection of the corneous layer, while he himself held that it is a congestion of the rete.

As regarded pigmentation, he believed that while psoriasis often does pass away without it, yet, when it occurs on the legs, pigmentation often remains after its cure, particularly when varicose veins are also present. He thought that in many cases it is impossible to make a diagnosis between eczema and psoriasis on the legs, for, if the veins are varicose, the scales of the psoriatic patches often look like those of eczema. Very acute psoriasis often resembles acute eczema closely. He once made sections of skin from a case which he took to be one of eczema, and was much puzzled to find the characteristic histological changes of psoriasis, an instance of which disease it afterwards proved to be.

He thought that psoriasis unquestionably does occur on the palms, associated, of course, with the disease in other parts. On the palms it presents no elevated masses of scales, but simply thickening of the skin, the patches being sharply limited. He had also seen patches of psoriasis on cicatricial tissue, and had preserved specimens from such a case.

DR. WHITE said that to his mind one of the most striking peculiarities of psoriasis of the scalp was the difficulty with which it could be distinguished from dandruff, and that doubt as to the true nature of an eruption situated on this part must often be felt for a long time. This is not the case, of course, when the disease extends beyond the limits of the scalp, when the amount of scale-formation varies according to the personal habits of the patient.

In his experience, pigmentation is often very marked after old psoriasis, not only on the legs, but over the entire body, and he had seen it almost as pronounced as the discoloration left after lichen ruber.

He attached but little importance to the seat of the eruption, and was accustomed to place no reliance upon its location as an aid to diagnosis. In his experience the patches were often as abundant on the flexor as on the extensor surfaces, and when they were few in number they were most abundant on the extensor surfaces.

One point which had not been mentioned in the paper was the fact that psoriasis sometimes terminates in verrucous new growths, and these in epithelioma.

DR. MORISON, alluding to the circumstance that only one of Dr. Greenough's patient was a negro, said that he himself had seen only two cases of the disease in persons of that race. In those, loss of pigment had followed the disappearance of the patches.

DR. FOX had seen an extensive eruption of psoriasis in a child three and a half years old. He had also seen a case in which the body was covered with the disease, and the extremities were free. He thought that too much stress was ordinarily laid upon the location of the patches,

on the knees and elbows, which, in many cases, are about the only parts spared. Too much stress was also laid upon the "robust health" of the victims of psoriasis, and he had observed that even in seemingly healthy persons the disease always grew worse when their general condition became bad; or, if women, when they became pregnant.

He had found the treatment of the disease much more satisfactory than that of many other cutaneous affections, and he always bore in mind the injunction of the late Tilbury Fox, that "the first thing to do in this disease is to lessen the congestion of the skin." For this purpose he gave alkaline diuretics, although he did not believe in "the gouty diathesis," and thought that the persistent use of large doses of alkalies often do more harm than good. He usually ordered a restricted diet, particularly as regarded meat, especially in hot weather. He also forbade tea, coffee, beer, and tobacco, and advised the liberal consumption of fruit and vegetables. He found that by this course he did more good than by prescribing arsenic or using active local treatment from the start.

As regarded local treatment, he would at present never think of using tar in psoriasis, believing that chrysarobin, used at the right time, was the best of all remedies. It should never be used when the patches were congested and might then cause the disease to spread. In case it did, he believed small doses of calomel and a restriction of the diet until the congestion was lessened would be the best plan of treatment. In many dispensary cases, in whom this plan of treatment had produced no better results than others, he had found that it would soon overcome the disease where the patients were taken into the hospital, where he could be certain that the orders were obeyed.

DR. HEITZMAN said that the most important point to be considered when beginning the treatment of a case of psoriasis was to ascertain whether the disease was acute or chronic. If acute, local treatment should not be resorted to. If chronic, the prospect of removing (not curing) the disease, by local treatment, was good. He had found that the eruption did itch sometimes, and that it occasionally occurred in persons in delicate health.

As regarded the etiology, he thought that even a simple miliaria might run into psoriasis, and he had seen one case in which the simple pressure of the edge of a book held in the hand had caused an eruption of the disease at the spot pressed upon. He did not believe in the causative efficiency of "over-acidity," or of "the gouty diathesis," and thought that we were at present absolutely ignorant as to the true cause of the disease.

As regarded treatment, he thought that alkalies would sooner or later poison the stomach, and never used them. In acute cases he was in the habit of forbidding meat, and using very mild local treatment, often nothing more than an ointment of boracic acid. He could not agree with Dr. Fox in discarding tar for chrysarobin in chronic cases. The latter undoubtedly does remove the disease in some cases, but he agreed with Jarish that it often hastened its recurrence. He frequently employed tar after chrysarobin with the best results. The disease he thought a very unpleasant one to treat, on the whole; in some cases, especially the acute ones, it would continue to extend in spite of all treatment. A particularly obstinate form of the disease was one which Til-

bury Fox had spoken of as a serofulous psoriasis, occurring in sickly persons, a form of the affection in which the patches were small and scattered, and covered with thin scales. He recalled to mind one case of this kind, at Kaposi's clinic, in which the latter hesitated at making a diagnosis between eczema and psoriasis.

DR. TAYLOR also thought that dermatologists were too apt to magnify chrysarobin as compared with tar in the treatment of this disease. In his opinion the former should be used only in cases in which the disease was chronic and localized, and not in the congestive variety. In some cases he had recently had under observation at Charity Hospital he had replaced chrysarobin with oil of cade with very decided benefit. He was convinced that a reaction in favor of tar in the treatment of psoriasis would ere long set in.

DR. HARDAWAY, speaking of the etiology of the affection, said that it was generally admitted that it was often hereditary. He thought that a peculiar kind of skin might be inherited in the same way as a peculiar color of the eye, and that if such were the case, almost any exciting cause, *e. g.*, traumatism, might lead to the development of the disease. He had seen an eczema persist for months and finally terminate in psoriasis; and he had seen an eczema clear up and leave islands of psoriasis behind, and he did not think it remarkable that psoriasis should follow seborrhœa, on account of the prolonged irritation attending the latter affection. Internal causes might excite psoriasis, and he had seen two patients develop the disease after the inordinate use of oatmeal. In its capacity for being excited by internal causes, the disease resembles eczema. In many instances the border line between the two diseases is very indistinct. Wise treatment of psoriasis, he thought, mainly looked towards diet. He restricted the use of meat, aided digestion, etc. Arsenic was useful in some cases, not from its power to remove any internal cause, but from its effects upon the skin itself. Locally, he had found chrysarobin very useful, especially mixed with salicylic acid, as recommended by Fox, especially in chronic cases. He had used tar but little, but often used a sulphur ointment, especially after chrysarobin.

DR. FOX, in answer to a question, said that he added the salicylic acid to the mixture of chrysarobin and collodion, because it softened the epidermic cells. He had found the preparation to act better thus.

DR. WHITE then read a paper on cases of

ANGIOMA PIGMENTOSUM ET ATROPHICUM.

It contained the report of two cases of this rare disease. The patients were brothers, aged fifteen and three respectively, of Russian-Polish family. In the older, the affection exhibited in a striking manner its three principal pathological features, an almost universal lenticular melano-derma, large areas of atrophic integument, and a considerable development of telangiectasiæ. So far as could be judged by the study of these cases, the process is primarily a melasma, the atrophica cutis and new growth of blood-vessels being sequelæ and very subordinate processes in extent.

In the child of three years, the disease was confined to the face and hands, and was represented only by the melano-dermic condition. In neither case was there an apparent beginning of the epitheliomatous change in the skin which so generally forms the last step in this mysterious series of pathological processes.

DISCUSSION.

DR. TAYLOR was entirely at variance with Dr. White as to the relations of the little red spots to the macules, and he spoke from the experience of seven cases observed over an area of years. He had carefully marked the locations of the lesions, and had watched the fading of the red spots and the appearance of brown ones in their places. The only safe way to draw conclusions about this disease was to watch it from its commencement. The history is usually first an obscure rash, then little red spots, and last the macules. He was absolutely certain that the maculation followed the hyperæmia.

DR. HEITZMAN said that in three cases he had studied, the connection between the hyperæmia and the macules was as Dr. Taylor had stated.

DR. GREENOUGH had seen two of Dr. White's cases. In the younger there was no evidence of angioma, the appearance being entirely pigmentary, all stages of discoloration being present. Neither was there any history of vascular dilatation. It didn't seem possible to him that each of the pigmented spots had been preceded by telangiectasis.

DR. TAYLOR said that in his cases the telangiectases were not always visible, appearing only when the parts were exposed to heat.

DR. FOX thought that the two processes of vascular dilatation and pigmentation were entirely distinct, and that it would be better to choose a meaningless name for the disease than the one used.

DR. WHITE said that he recognized a great variation in this disease according to the particular case, but must insist on the correctness of his own observations. He had observed the cases in hot rooms on very hot days, but never found any hyperæmia or chronic enlargement of vessels in the younger case. In the older case there is, at spots, no pigmentation, and there is also no enlargement of vessels. Although the three processes, permanent enlargement of vessels, pigmentation, and atrophy may be associated, they have, as far as individual lesions are concerned, no connection whatever, as far as his observation went.

First Day—Evening Session.

DR. HYDE read a paper on the

RELATIONS OF LUPUS TO TUBERCULOSIS.

The author began with a tabulated statement of all the cases of lupus vulgaris reported to the Statistical Committee of the American Dermatological Association during the last seven years; and compared the frequency of the disease as recognized in this country with that reported from the hernia hospitals, adducing reasons for believing that the American

figures furnished a fair index of the relative preponderance of the disease as it exists in this country.

He then gave details of twenty cases of lupus vulgaris observed by him in Chicago, being the last twenty recorded in consecutive order.

Clinical deductions from these records were then added, showing, according to the author, that there was a remarkable absence in the family record of the twenty patients of cases of pulmonary tuberculosis, scrofula, and allied affections.

The teachings of the two schools, represented in the past by prominent German and French authors, were then reviewed, and finally the later investigations of the subject described, demonstrating that lupus vulgaris was the result of bacillus infection, not to be differentiated in the external characteristics of the parasite from bacillus tuberculosis.

The following clinical facts were then cited in support of the later teaching on this subject, as bearing on the vital point in the author's argument, viz. : that lupus vulgaris was not the result, as has long been taught, of a tuberculosis or other systemic diathesis, but was the product of a local infection by bacilli, entirely unassociated with any constitutional vice, diathesis, or predisposition.

1. The unimpeachable character of the family record in by far the larger number of all cases of lupus vulgaris.

2. The fact that the disease is, in its inception, a disorder of the period of childhood, when, for the most part, the habits of the child are favorable for inspection.

3. The several sites of predilection of the disease are those most liable to such infection.

4. The failure of the disease to spread by inheritance.

5. The remarkable tendency of lupus vulgaris to a cutaneous limitation.

DR. WHITE read a paper on

THE TREATMENT OF LUPUS BY PARASITICIDES.

In this communication he sketched the recent developments in our knowledge which established the common and bacillous origin of tuberculosis, scrofulosis, and lupus, and the rational attempts which have followed to overcome the latter phase of the disease by the external use of parasitocides. He reported the results of these methods in twelve cases of the disease which had been under his observation during the past eighteen months. From these experiments he concluded that we may probably be able to substitute for the painful and unsatisfactory surgical methods hitherto employed against the disease, such very simple applications as are capable of destroying the bacilli in the lupus tissues. Among the most promising of these in his experience were corrosive sublimate and salicylic acid.

DISCUSSION.

DR. FOX said that his experience with corrosive sublimate in lupus was but slight and not so satisfactory as that of Dr. White. He had seen it do good, but was not able to believe that it did so by virtue of its parasiticide qualities, for the reason that it was often of service in causing the disappearance of acne tubercles. He had been surprised at hearing scarification spoken so disparagingly of in the treatment of lupus, as he was convinced that no other plan of treatment would accomplish so much in destroying the new growth, and leaving so little cicatricial tissue. He detailed the case of a young lady with lupus of the nose and cheeks, which had caused ectropion. He had treated her for eight months with scarification, removing the greater part of the disease, obtaining a brilliant result, and that without increasing the ectropion. In other cases, where loss of tissue was less to be avoided, he often used chemical means. Frequently pyrogallie acid, 10 or 20 per cent ointment had speedily removed nodules and diminished the chances of a relapse. The use of mercurial plaster afterwards he thought often did good, and he was of the opinion that a combination of the three measures he had mentioned was perhaps the best plan of treatment.

DR. SHERWELL said that at the risk of being considered too conservative or old-fogyish, he would express his profound disbelief in the theory advanced by Hyde that traumatism, or the contact with dirt from fingers or clothing, could cause lupus. He agreed with Fox as to the melting away of tubercles under mercurials. He believed in the old-fashioned view, that scrofuloderma or lupus means a condition of hereditary syphilitic degeneration.

DR. ROBINSON said that he was undecided as to the connection between lupus and tuberculosis, and could not yet accept the view that the bacillus of the two diseases was the same. Although we know that the lungs are the favorite seat of the bacillus, yet lupus cases may go on for years without developing tuberculosis, although constantly inhaling bacilli. Morphological similarity is no proof of identity of nature. Lupus tissue and pulmonary nodules do not correspond, except as to the general characteristics of all infectious granulomata; their situation, mode of spreading, and time and manner of degenerating being different. He did not think that a lupus could ever turn into an epithelioma, which Dr. Hyde had stated to have occurred in two of his cases, since the former has its seat in the corium, the latter in the epidermis; as to the treatment of lupus by parasiticides, he had used mercurials a great deal in this disease for the past six years, and all that he had ever seen accomplished was the rapid breaking down of the central portions of tubercles (never of the periphery), with but temporary benefit.

DR. GRAHAM agreed with the last speaker that the identity of the two affections was not proved. He thought that the case cited by Dr. White, in which lupus was also present in the larynx, was proof of the different nature of the two affections; for in that the patient must have constantly inhaled bacilli, and yet no tubercle developed, although the lungs were predisposed thereto.

DR. TILDEN thought lupus a form of tuberculosis of the skin, although not all tuberculosis of that organ was lupus.

DR. ROHÉ did not believe that oleate of mercury and calomel were

parasitocides. He was now treating a case of lupus with lactic acid with beautiful results.

DR. HYDE said that Dr. Taylor had suggested to him the use of bichloride of mercury and tinct. benzoin. He had used it in lupus and infecting chancre, and had found that, although it caused pain at first, this soon stopped. He thought it a very serviceable dressing. As to what Dr. Sherwell had said about the etiology of lupus, he himself thought inherited syphilis inherited syphilis and nothing else, and that it had nothing to do with any other disease. Dr. Robinson's argument against the identity of lupus and tuberculosis was, he thought, refuted by syphilis, the lesions of which, such as mucous patches and gummata, differ as much as tuberculosis and lupus.

DR. WHITE said that Dr. Fox's statement, that the good work of the bichloride in lupus was not due to its parasiticide action, was refuted by the fact that substances which cause ordinary inflammatory tissue to break down do not cure lupus. When the non-identity of lupus and tuberculosis was attempted to be shown by the fact that the former did not give rise to the latter, he would point to the circumstance that neither syphilis nor leprosy lesions spread to other tissues. This is a peculiarity of all bacillar diseases.

DR. TAYLOR remarked that the ointment used by Dr. White had been employed one hundred years ago, by Sedillot, for the cure of syphilis.

DR. FOX mentioned that he had recently observed the development of tuberculosis of the lungs in a patient suffering from a lupus of the nose.

DR. HARDAWAY then read a paper

ON THE TREATMENT OF PORT-WINE MARK BY ELECTROLYSIS.

In it he stated that, in the treatment of this malady, the object was to excite sufficient inflammation to cause occlusion of the vessels. Electrolysis seemed to be the most convenient way of doing this. At first, he had used a bundle of needles, but after their use the reaction was too violent, and there was also a great tendency to keloidal development, so that he now employed only the single needle. It is important to allow a period of some weeks to elapse between the operations. The histories of three cases were given, in which this method had been employed. In two, the result was very gratifying; in the third, but little was accomplished.

DISCUSSION.

DR. WHITE had recently used the treatment spoken of in the paper in a case of unilateral port-wine mark, and also in others. He could not state that he had produced a complete cure, but great improvement had taken place in all, and in some diseased patches complete obliterations of the vessels had resulted. He had also used the method in cases of rosaceous redness with telangiectatic new growths with marked benefit, which was often but temporary, however, the disease seeming to have a strong disposition to recur.

DR. WIGGLESWORTH thought that not enough stress had been laid

upon the advantages to be derived from cutting the dilated vessels across in two places, and rubbing in a solution of persulphate of iron.

DR. HYDE had used the method recommended by Dr. Sherwell, of tattooing port-wine marks with chromic acid, with good results. When electrolysis was recommended he had used it, and in small telangiectases with good results. But his results with port-wine mark were different. He had found it best, in using this means of treatment, to insert the needle at distances of from one-quarter to one-half an inch. Not long ago a patient applied to him, stating that he was about to be married, and had something wrong with his penis. On examination, he found what he had never before seen, viz., an organ covered with a port-wine mark. It measured nine inches from root to tip, and four and a-half inches in circumference. The glans had a peculiar "peppery" appearance, and the dilatation of the vessels extended down the inner aspect of one thigh. The organ was otherwise normal in all respects, except that when erected it never rose above the horizontal line.

DR. FOX remarked that the so-called "spider cancers" or simple telangiectases were usually readily amenable to treatment, but that it was different with port-wine mark. Over no other disease had he spent so much time and thought in devising an efficient plan of treatment, and in no disease had he so completely failed. He thought that the use of electrolysis was in many instances better than any other plan recommended. He had tried Dr. Sherwell's plan, that of puncturing the patch and rubbing in carbolic acid, before that gentleman had written about it. He was accustomed to pass the needle in obliquely and deeply, in the hope of striking the artery of supply. In nævus of the lip he had often entirely transfixed the part.

DR. SHERWELL said that in some port-wine stains the arterial element seemed to predominate, producing an intensely red patch. In such cases he had frequently had very bad results of treatment. He thought the best results were obtained in cases characterized by lividity of color, in which the venous element was predominant. He had since his first experience with tattooing felt less and less enthusiastic over the value of the method of treatment which he recommended, and was now somewhat tired of it. He had several times seen keloid follow the operation. He had once injected seventeen drops of carbolic acid, and two days later twelve drops into a cavernous tumor on the face of a child five months old. Severe reaction followed, the eye being entirely closed for a few days, but the child recovered entirely. A few days later he had injected twenty-three drops of the same agent into the face of a child seven months old. The practice he thought a very dangerous one, and he would not repeat it, and only did it in those two cases as a dernier ressort.

DR. TAYLOR remarked that port-wine marks on the glans penis and the tegumentary sheath of that organ were not very uncommon.

DR. ROHÉ had seen a cirroid aneurism of the penis.

DR. DENSLOW had recently had a case brought to him of a child three months old, with a vascular tumor on the labium majus, covering also the lower part of the nymphæ. It first appeared at the age of one month, when it ulcerated over one-third of its surface. The ulcer remained stationary for two months. He applied a solution of gutta serena as a placebo, and strange to say, two days later, the entire mass had sloughed out through its entire depth. The ulcer left behind healed

in three weeks. He raised the question whether the compression had had any influence in producing this result.

DR. HYDE thought not. Such ulcerations were common and often sudden, and might possibly be due to a clot in the nutrient vessel.

DR. HARDAWAY said that he believed that up to to-day electrolysis was the most agreeable and successful means of treating port-wine mark. He recommended mopping very hot water upon the part after the operation, as it notably lessened the inflammatory reaction.

DR. SHERWELL then read a paper

ON A MOOT POINT IN THE ETIOLOGY OF PSORIASIS.¹

DISCUSSION.

DR. ROBINSON expressed his belief that the physical condition of the patient had nothing whatever to do with psoriasis. He had seen the disease in chlorotic, anæmic, tubercular, as well as in healthy persons. It was ordinarily an hereditary, purely local trouble, an hyperplasia of the skin.

DR. GREENOUGH held the same opinion, but had found that a very large proportion of those suffering from psoriasis were robust.

DR. HEITZMAN thought that the simple truth of the matter was that we knew nothing whatever about the cause of the disease, and that all speculation about "the rheumatic diathesis, suboxidation, and overacidity of the system" was arrant nonsense.

Second Day—Morning Session.

DR. FOX, by permission of the Association, presented a photograph and read the histories of two well-marked cases of dysidrosis or pompholyx.

The first case, for want of a better term, he classed under this heading. The patient was 29 years old, and had always perspired freely. Four years ago the eruption began on the palms of the hand and had remained ever since. At one time the soles of the feet were also affected. The skin of the hands was thick and of a dark hue, dotted with numerous epidermic elevations, of hemp-seed size. The spots had never been moist, there was no itching, and no desquamation. No fluid was obtained by puncturing the lesions.

The second case was that of a middle-aged woman, of good health. The eruption, of five years' standing, is on the face, and consists of numerous large and small clear vesicles.

DISCUSSION.

DR. DUHRING said that the case whose photograph was shown seemed to be a true dysidrosis, an inflammatory affection entirely distinct from pompholyx.

¹ See page 293.

DR. ROBINSON said that dysidrosis consisted of an obstruction of the sweat ducts in the corium. It might last months or years, the lesions showing no tendency to grouping or spreading. There was no relation between the two diseases, dysidrosis and pompholyx. Sweat acts simply mechanically when retained in the skin, causing no inflammation. Pompholyx closely resembles pemphigus, and is a neurosis.

DR. STELWAGON had seen at least six cases similar to the one pictured in the photograph. He was unable to decide whether they were instances of dysidrosis or sudamina.

DR. ROBINSON then read a paper on

MICROLOGICAL STUDIES IN RINGWORM AND FAVUS.

The first portion of the paper was devoted to a consideration of the conditions favorable to the growth and development of the hyphomycetes or moulds; and the remainder to a description of the anatomical seat of the fungus in the two diseases, the changes produced in the tissues invaded, and the changes, if any, in the surrounding tissues.

He maintained that a suitable nidus from which they can obtain material for their development, together with a free supply of oxygen, moisture, etc., is necessary for their active growth. In defence of the view that a suitable nidus is necessary, and that this condition as a rule is not present in normal epidermis, he said that practically we know that every epidermis is not equally suitable for their growth, that the epidermis of children is a more favorable ground for favus and ringworm than that of adults, whilst the latter is more favorable for *tinea versicolor*. The epidermis of every child is also not equally favorable for the growth of favus or ringworm, neither is that of adults equally suitable for *tinea versicolor*. Some change in the vital energy of the tissues, consisting, as a rule, in a lowered vitality, or in some alteration of its metabolism, is necessary to enable the organisms to develop (Boyd). Practically, we see in the case of ringworm how a lowered vitality of tissue, as occurs in scrofulous or ill-nourished children, is a favorable condition for the growth and development of the fungus as compared with the disease in the robust and well nourished. In the former the disease is very difficult to remove, and it may be absolutely necessary, in order to be successful, to combine internal medication with local means.

With reference to the anatomical seat of the fungus in favus, he never found it to pass into the rete, corium, external root-sheath of the hair or hair-bulb, unless these parts had become structurally changed from pressure or inflammation. In these observations he is in accord with Unna, and against Malassez, Hoggan, etc., who maintain that the fungus penetrates, grows downward through the rete into the corium. It may be present in these situations, but only when it replaces the tissues previously destroyed; it does not grow in the normal, succulent, living tissue.

The depressed centre of the favus scutulum owes its formation in great part, no doubt, to the anatomical relations of the upper epidermis cells to the cuticula of the hair—their close connection and difficulty of elevation by the growing favus mass beneath, as compared with the surrounding epidermis, as already described by Kaposi; but the author believed that another important factor was the structure of the cup itself. The peripheral portion consists of a dense collection of mycelium, imbedded in a granular debris which also contains many micrococci; the central portion, on the other hand, consists almost exclusively of spores which are not very densely packed, hence the peripheral part of the favus cup is much firmer and more resistant to external pressure than the central part and does not so readily sink in.

The fungus elements act locally and mechanically upon the tissues, the epithelial cells and layers are more or less separated from each other, the amount depending upon the amount and situation of fungus present. The rete cells are compressed to a greater or less extent, as also the granular and stratum lucidum layers. In advanced stages of the disease, all these structures undergo degenerative changes and become more or less destroyed; first the corneous layer and then the other layers in succession, either in consequence of pressure from the favus elements or from inflammatory changes proceeding from the corium.

The changes in the hair and hair-follicle area are similar to those in the epidermis just described. The hair-shaft is invaded directly from the fungus lying between the inner sheath and the cuticula, or indirectly by gaining entrance through the cuticula at some point and then passing upward and downward along the shaft, separating the elements. The hair-shaft is also changed in nutrition, even when not invaded by the fungus, and in consequence shows a longitudinal striation caused by air between the fibres—an appearance greatly resembling that caused by mycelium. This appearance, first described by Aubert, is very characteristic of favus, and is not met with, the author believes, in *tinea trichophytina*. Strangely, this author denies the invasion of the hair-shaft.

The changes which occur in the cutis are those of inflammation and retention. The former varies in intensity from the slightest grade to complete destruction of the epidermis and upper part of the corium, or even of its deeper part and substitution by cicatricial tissue. The changes produced by retention are cystic degeneration of the sebaceous and sweat ducts. The rarity with which sebaceous glands are found in cases of favus is noteworthy. The author believes they are very early destroyed by the inflammatory process.

In *tinea trichophytina* the fungus was found in the corneous layer, in the rete, and even in the corium, as well as in the hair and its sheath. In accordance with the view of several English authors, the fungus was

found also upon the free surface, as well as between the epithelial cells. In *tinea trichophytina capitis* the greatest number of fungus elements was found in the hair and the funnel-shaped part of the hair follicle. The cuticula is frequently not invaded in the early stages and sometimes not until the hair is more or less destroyed. The peripheral part of the shaft, excluding the cuticula, is also attacked by preference to the medullary part. The fungus also extends in the hair much further above the free surface than it does in *favus*.

There may be no appreciable inflammatory changes or they may be marked. In the former cases the clinical symptoms may resemble very closely those of *alopecia areata*, and a microscopical examination of the hairs be necessary to decide as to the nature of the disease. In *tinea trichophytina barbæ* the same conditions are present as in the scalp, but the inflammatory changes are always decided when the follicle is invaded by the fungus. Whether the fungus penetrates the corium or not could not be decided, owing to the inflammatory changes in the corium in the sections examined, but it is more than probable it does.

In *tinea trichophytina corporis* (*tinea circinata*) the fungus was found in the epidermis and even in the corium in small numbers. But few were found in the hair shaft, although they may be abundant in the mouth of the follicle. The fungus penetrates the corneous layer and may spread by travelling along the free surface or between the corneous layers. Having found a suitable nidus, they grow and multiply and *produce the slight elevation* of the skin observed in ringworm. Unless the inflammation is marked, the lesions of ringworm, the slightly elevated rings, or papules, or indications of vesicles are formed of fungus elements and changed epithelial cells. The changes in the corium may be slight, or there may be sufficient inflammation with exudation to produce vesicles or pustules.

DISCUSSION.

DR. WHITE could not agree with the statement of the author that the disease, ringworm of scalp, was more liable to affect ill-nourished scrofulous children. In his experience, the fungus of this disease exhibited no choice in the selection of its host, he having found it to affect its subjects independently of individuality, it affecting all if given an opportunity, well or sick. Ringworm of the beard, in the vast majority of instances, occurs in perfectly healthy men.

So far as cure of the malady was concerned, he had never seen the necessity of internal treatment, which he would employ only for the reduction of secondary phenomena, but not with a view to the destruction of the fungus.

He was astonished at the stress so often laid upon the so-called vesicular nature of the eruption. He had never seen any vesicles in it, and could never understand why the disease should have been called a herpes.

DR. SHERWELL, speaking of the treatment, said that saturating the scalp with oil he considered a parasiticide measure, it acting by depriving the fungus of air.

DR. PIFFARD agreed with Dr. Robinson as to the systemic conditions usually found in those suffering from ringworm. He considered kerion a disease of the scrofulous, and had never seen it in the robust. He did not consider it a third stage of ringworm, as Dr. White had called it.

DR. DURING said that, as to the condition of the soil chosen by ringworm, he had always held that a peculiar condition of the surface was necessary for the propagation of the growth. He did not think that the subjects must necessarily be below par, but had found that they usually were. He did not believe that all persons were subject to ringworm. Some peculiar (unknown) condition of the epidermis must exist to render them liable to it. Robust children get well more rapidly than delicate ones. He had seen true vesicles in ringworm of the general surface.

DR. HEITZMAN agreed with Dr. White that the disease affected the robust as well as the delicate. He had seen strong healthy men covered with ringworm from head to foot. No internal treatment was needed to cure the disease, and he was surprised to hear gentlemen still talking about the system being at fault in the disease. In his opinion there was no basis for any such belief.

DR. DENSLOW had recently seen a large number of cases of the disease occurring on lumbermen of the Northwest, who were usually men of iron. They always recovered without internal treatment.

DR. PIFFARD remarked that chromophytosis occurred twice as often in syphilitic subjects as in non-syphilitic, and he had repeatedly seen it get well under antisymphilitic treatment without local treatment. Whether or not this was the result of the elimination of mercury by the skin he was unable to say. Mosquitoes also showed a preference for certain persons.

DR. HARDAWAY said that, although he had a preconceived notion that ringworm attacked only delicate persons, he had never been able to prove it by observation.

DR. ROBINSON said that, as external conditions made a difference as to development of the fungus, so also did the soil on which it grew make a difference. The disease was much more frequent in children than in adults, and in hospitals some children get it while others do not, and some were much more easily curable than others. It was a well-known fact that the bacillus anthracis could be successfully inoculated in young dogs, but not in old ones. Ringworm untreated gets well at puberty, on account of the fact that the tissues change.

DR. HEITZMAN then read a paper on

THE STRUCTURE OF THE DERMA AND THE DEVELOPMENT OF ELASTIC TISSUE IN IT, WITH DEMONSTRATIONS.

In it he stated that the derma is made up of interlacing bundles of so-called fibrous connective tissue, which are comparatively coarse in the middle and lower portions of the derma, and delicate in the papillary layer. The bundles look striated, owing to the presence of dense spindles, representing the glue-yielding basis substance proper, being united with

each other by a less dense, so-called cement substance. Real fibres appear only after teasing or after application of chemical reagents. Between the bundles lie the protoplasmic cords, freely supplied with nuclei; and, according to the general spindle-shape of the bundles, branching and connecting everywhere. Isolated cells or connective-tissue corpuscles do not exist in the derma, nor in any other variety of fibrous connective tissue, such as tendon, aponeuroses, ligaments, etc. Starting from the protoplasmic cords, delicate offshoots pass into the bundles and freely connect with an extremely delicate reticulum of living matter which traverses the basis substance to such an extent that only the meshes of the reticulum contain the glue-yielding basis substance. The delicate interstices between the spindles or fibres, the cement substance, is again traversed by minute spokes of living-matter. Thus the whole basis substance is endowed with properties of life, and in inflammation the formation of inflammatory or eventually pus-corpuscles, though starting from the protoplasmic cords, goes on from the latter as well as from the bundles.

With advancing age, the interstices between the bundles, filled with protoplasm, decrease in size, whereas the volume of the bundles increases. The interstices at length become reduced to narrow slits, and at the edges of the bundles, where the contact between them is narrowest, a very dense elastic basis substance forms, assuming the shape of elastic fibres. The branching of these fibres becomes intelligible only by assuming a direct transformation of the protoplasm into elastic substance along the edges of the bundles. In some benign tumors of the skin, such as fibrous papilloma, etc., the formation of elastic tissue goes on in a rather premature and rapid manner. All the three varieties of basis substance of the derma, the glue-yielding, the cement, and the elastic substance, are direct products of protoplasm, and all of them are possessed of properties of life.

DR. HARDAWAY read a paper on

MULTIPLE MYOMATA OF THE SKIN—ILLUSTRATED.

DISCUSSION.

DR. DUHRING said that the form of the lesions resembled a case of his own which had been alluded to in the paper. He thought that clinically it was very difficult and even impossible to make a diagnosis of the true nature of the affection. In his own case (which was a true neuroma), the pain was intense on slight, but relieved by firm pressure.

DR. HEITZMAN said that the specimen under the microscope showed that the derma was almost entirely transformed into myomatous tissue. He had seen only one specimen of the kind in his laboratory in ten years. He believed that the pain of which the patient complained was not due to a new-formation of nerves, but to the pressure of the growths upon

already existing nerves. The specimen shows that no new-formation of nerves is necessary in order that a tumor may be painful. A myxoma, myoma, or a chondroma may be painful.

DR. MORISON next read a description of

A CASE OF TYLOSIS OF THE HANDS.

A negro, aged 32 years, had both hands much affected with this disease. He was a fireman on a steamer, and had been working as such for ten years. The constant rubbing of the hands upon the handle of the shovel had caused callosities and subsequently ulcerations. On the left hand the ulcerations were followed by loss of tissue and bone, so that it was very much deformed. The third phalanx of two fingers was entirely gone, and the other fingers were in a state of disease which showed their ultimate demolition. The thumb of the same hand had a patch of ulceration upon its inside surface, which in a few weeks exposed the first joint, the bones becoming necrosed. The ulcerations started first as callosities. There was absolutely no pain, nor had there ever been any. The man picked out pieces of bone himself and threw them away. He had no history of syphilis, was muscular, healthy, and without any disease anywhere else on the body. No treatment, excepting rest, was advised; but the patient, as long as he suffered no pain, was not willing to give up his lucrative occupation.

Plates were shown illustrating the condition of the hands at that time.

DISCUSSION.

DR. WHITE said that the result of the disease was so extraordinary that he was strongly inclined to believe that there was some antecedent change in the system of the patient to cause the necrosis of the bones of the fingers.

DR. TILDEN thought that the disease in this patient bore a strong resemblance to the "mal perforant du pied" of the French. He also said that the case reminded him of *lepra mutilans*.

DR. DUHRING expressed the opinion that there must have been some deep-seated nervous change in the system of the patient, such as occurs in perforating ulcer. He did not believe that simple local irritation could excite such destructive changes.

DR. MORISON said that he had been unable to find any evidence of disease of nerves in the case, and that the local irritation was the cause of the trouble was shown by the circumstance that the left hand which ran up and down the handle of the shovel used in the man's occupation was much more severely affected than the right, which simply grasped the handle of the instrument.

Evening Session—Second Day.

DR. DUHRING read a paper entitled

THE RELATION OF HERPES GESTATIONIS AND CERTAIN OTHER FORMS OF
DISEASE TO DERMATITIS HERPETIFORMIS.

Attention was briefly directed to the previous article of the reader on dermatitis herpetiformis, and to a paper showing its identity with the impetigo herpetiformis of Hebra; also to a preliminary note on the relation of this disease to herpes gestationis and other similar forms of cutaneous disease, read before the Association at the last meeting.

The object of the present communication was to prove the identity of so-called herpes gestationis with the vesicular variety of dermatitis herpetiformis, and to show that the term herpes gestationis is a misnomer, the affection being found in men as well as in women. Secondly, that certain other so-called forms of herpes, such as "herpes pemphigoides," "herpes vegetans," "herpes pyæmicus," etc., as well as certain cases regarded by the reporters as "peculiar forms of pemphigus," must be viewed as examples of this disease; and, finally, that instances of the same affection are also met with in literature under the title of hydroa, and under divers other captions. Numerous cases from English, French, and German literature were cited. The paper of Dr. Duhring was stated to be looked upon as supplementary to the preliminary notes referred to, and embodied the results of considerable research into literature. If the views put forth proved to be correct, a great deal had been gained for dermatology in bringing these peculiar forms of disease together.

DISCUSSION.

DR. WHITE remarked that since the last meeting of the Association he had seen five cases of dermatitis herpetiformis, two of which he had treated. The more he had seen of the disease, the more he thought the title given it by Dr. Duhring a misnomer. He thought it should be called dermatitis multiformis, as he had found that the herpetic element was only exceptionally present, being entirely absent in some cases. He had never seen a case of the disease which he would have been apt to confound with herpes, though he had seen some which he might have taken for eczema or pemphigus. The vesicles, in his experience, always failed to present the tendency to grouping so characteristic of herpes.

DR. ROBINSON held the same view as the last speaker. He had seen five or six cases of the disease. He thought the name hydroa a sufficiently comprehensive one, and not misleading, as long as we know no more of the affection than at present. He thought the inflammatory changes met with were secondary to some internal derangement.

DR. HYDE thought the term herpetiform preferable to the others which had been suggested, since tradition favored it, as shown in the well-known name impetigo herpetiformis. Although he fully recognized

the multiform character of the lesions, yet, in the cases he had seen, there was an unmistakable suggestion of herpes.

DR. FOX exhibited a photograph of a case which might be mistaken for herpetiform dermatitis, although it was a well-marked case of multiform erythema. He, too, did not like the name given the disease by Dr. Duhring. In his case there were vesicular and bullous lesions and typical patches of herpes iris, and in one place it showed an annular bulla, made up of a circle of vesicles which had coalesced.

DR. DUHRING could not agree with the other speakers in their objections to the use of the term "herpetiform." This characteristic was present in a more or less marked degree in all the cases, and the term was, therefore, both appropriate and expressive. Hebra recognized the herpetiform nature of his cases, and a thorough search of the literature of the subject had taught him that almost all writers on the subject did likewise. He had used the term multiform dermatitis to distinguish one variety of the affection, and that a very important one. The adjective did not, however, seem to him sufficiently expressive. He did not consider the disease a rare one. He thought that we stood on the threshold of our knowledge of the disease, and he himself was constantly learning something new about it. It was an immense process, capable of indefinite elaboration, which will be done as time goes on. Cases varied greatly as they presented themselves, as would naturally be expected in so elaborate a process as the affection represented.

(To be concluded.)

Selections.

HERPES TONSURANS MACULOSUS.

THE name herpes tonsurans maculosus is given to an acute eruption disseminating more or less over the entire body, and caused by the vegetable parasite, the *trichophyton tonsurans*. It is comparatively infrequent in its occurrence here, and though it has a common origin with ordinary ringworm, yet it differs from this in the manner of its invasion, the acuteness of its development, the extent of surface implicated, and in its general course. The individual lesions retain, however, the salient characteristics of the ordinary form.

The conditions under which it may occur are the same as those favoring the development of ordinary ringworm, viz., damp lodgings, clothes, etc.; immediate infection, etc. In none, however, of the many cases which I have observed, have I been able to trace its having been communicated from one person to another, even though all conditions for such communication were present.

In all probability, an outbreak of herpes tonsurans maculosus is due to multiple infection. The spores of the parasite, obtaining access to the skin at many points, develop rapidly under suitable conditions. The primary lesions thus formed may again serve as foci of the infection, inasmuch as the scales of epidermis, being detached by the movements of the body, carry the spores to other as yet unaffected portions, where the process begins anew. A succession of out-

breaks thus appears until, in a short time, the patient is covered with the lesions in all stages of development.

There is no particular localization to the disease, and no portion of the body is invulnerable to its attacks. The outbreak of the affection may be preceded by malaise, some fever, loss of appetite, and symptoms of general disturbance. In the course of the disease, the irritation and consequent loss of sleep in children may give rise to serious anxiety.

The eruption first appears in the form of pale-red papules about as large as a millet-seed, which disappear on pressure, and are slightly elevated. On parts where there is much perspiration, the color of the lesion is a dark-red. Shortly after the appearance of the papules, peripheral growth has ensued, and slight exfoliation will be observed in the centres, while the edges remain smooth and red. The lesions are at first circular, but, as they grow larger, many become oval in shape, their long axes lying in the direction of the cleavage lines of the skin. Their development is at first rapid, and in the course of a week or ten days they attain the size of a twenty-five cent piece, or even larger. When the edges of two or more of the lesions come together, the portions which were in contact disappear, and a gyrate form of eruption remains. As the lesions increase in size, their edges become more elevated, are of a bright-red, and scaly, fading gradually away into the surrounding tissue. At times vesiculation is observed. The central portions are more or less scaly and in process of involution, but in the larger lesions these squamæ have ceased forming, and the skin may be found perfectly normal. As they become older, they acquire a dirty, light-brown color, and they approach more nearly to a typical ringworm. Many of the lesions, however, do not follow this course, but abort and disappear a few days after their first appearance. The itching of the eruption, in uncomplicated cases, is not very severe.

If left to itself, the disease runs its course in from two to six months. The edges flatten out, the erythematous condition disappears, desquamation occurs, and the skin becomes again normal. Slight pigmentation may remain for a variable length of time. One spot often remains, especially on those parts of the body which are well protected, and may serve as a focus for reinfection. On microscopical examination of the epidermis scales, the mycelia and conidia of the *trichophyton tonsurans* will be found but very sparingly in the younger lesions—contrary to what occurs in ordinary ringworm. As the lesions, however, become larger, and approach more nearly to the type of the later disease, the presence of the parasite is easily demonstrable.

The diagnosis presents no special difficulty, if the distinguishing characteristics of ordinary ringworm are kept in mind. Only at its first appearance can it be mistaken, and its development is so rapid that ordinary observation very soon clears up any doubt as to the nature of the eruption. Should an eczema complicate the case, the finding of a fresh and uninjured lesion will demonstrate the real disease present.

The treatment is in substance the same as that used in the other forms of disease caused by the *trichophyton tonsurans*. It should be borne in mind that it is absolutely necessary to apply the anti-parasitic remedy to the whole body, even upon those portions which appear perfectly normal. It is important to check the progress of the disease as quickly as possible, and the longer it is temporized with, the greater the difficulty in curing it, and the greater the risk that an eczema or a dermatitis may arise to complicate it. After the arrest of the affection, and there is a certainty of the death of the parasitic spores, the skin should

be protected by the inunction of some bland salve, and powder should be freely used. More or less exfoliation of the epidermis occurs, and the skin becomes normal in from a week to ten days.—GEORGE T. ELLIOTT, *N. Y. Med. Journ.*, July 4, 1885.

PUMICE-STONE IN PITYRIASIS VERSICOLOR.

OF the numerous remedies proposed for the cure of this affection, such as the lotions of nitric acid, of sulphur, and of borax, the pomades of mercury and tar, none rivals a soap made from pumice-stone in destroying the microsporon. The action of the alkali contained in the soap upon the skin, together with the mechanical effect of the powder of pumice-stone, is certain to produce the desired result. Prolonged frictions should be made morning and night with soap prepared according to the following (Vigier's) formula:

Black soap.....	lb. ij.
Pumice-stone	lb. ss.
Mix carefully.	— <i>Ther. Gazette</i> , July 15, 1885.

Review.

LEHRBUCH DER HAUT- UND GESCHLECHTSKRANKHEITEN. Von DR. EDMUND LESSER. Erster Theil. Haut-Krankheiten. Leipzig: F. C. W. Vogel, 1885.

This book belongs to the class of minor works which aim to give in brief a complete conspectus of the subject.

In most respects, the author successfully carries out his object. His description of the various diseases, though concise, are accurate and excellent. Histological considerations are omitted as regards the majority of affections of which he treats, and when given, are exceedingly brief. He enters more fully into etiological questions, but, in the main, from standpoints which would not be considered sound by the majority of dermatologists of this country. In the matter of treatment, the book is specially defective, the author appearing to be uninformed as to the various methods in vogue in other, and especially in this country. As a whole, the work may be considered as a foundation on which the author can, in a second edition, if he chooses, build a useful and instructive treatise.



Dr. Ripley's case of Bullous Eruption in a child.

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CASE OF BULLOUS ERUPTION IN A CHILD.

BY

J. H. RIPLEY, M.D.

WALTER M. was a fair-haired, bright boy, 4 years old, and born of exceptionally healthy parents. His maternal grandmother suffered from attacks of chronic rheumatism, and a paternal aunt had died of "hasty consumption." Otherwise, so far as known, there was no hereditary tendency to disease in the family. Of the four children, this boy, an older sister (10), a younger brother (3), had all three been subject to frequent attacks of urticaria. The other child, also older (7), had escaped. Four weeks previous to the present illness, Walter had had a mild attack of measles which was immediately succeeded by a sharp and persistent attack of urticaria. This lasted, intermittently, for over two weeks. As it was apparently finally declining, circumscribed areas of violent dermatitis appeared successively on different parts of the body. Only the palms of the hands and the scalp proper remained uninvaded. The first patch, pear-shaped and about five inches long, appeared on the outer aspect of the right thigh. The epidermis was soon lifted by serous exudation and a large bulla formed. At first the contained fluid was clear and transparent, but rapidly became turbid. Invasions of new areas speedily followed, each succeeding day developing new crops of bullæ, the disease showing at first a preference for the buttocks and lower extremities; later the upper extremities, neck, face, and even the mucous membranes of the nose and mouth.

The blebs varied much in size and also in shape; some were nearly circular and from the size of a ten-cent piece to that of a trade-dollar;

others were ovoid, triangular or rectangular, and several inches long. The dorsum of the right foot was completely covered with a single bleb. The back of the right hand, including the fingers as far as the nails, was covered with one continuous vesicle. The entire back of the neck was involved. The gluteal and perineal surfaces were entirely covered, the inflammatory process even extending half an inch inward, over the mucous membrane of the rectum.

The disease lasted about two weeks, and for several days during its height the constitutional symptoms were alarming. The stomach was so irritable that only small quantities of the simplest liquid food could be tolerated. The temperature, which earlier had ranged from 101–2°, now rose to 104°, and there was great prostration and at times muttering delirium. The boy would lie for hours without moving a limb, and much urging was required to induce him to take nourishment. As nutrition became impaired, the skin exudations consisted more and more largely of blood; some of the blebs looked as though they contained pure arterio-venous blood. Extreme fragility of the walls of the blebs was generally associated with bloody contents, became early ruptured, and tearing away of the protecting epidermis generally took place, leaving large bleeding surfaces which were difficult to manage. Hemorrhages occurred also from the mouth, nose, rectum, and from beneath the finger and toe nails. At this time the patient was a pitiable sight. He had rapidly lost flesh, his eyes were sunken and dull, his little wasted hands trembled like an aspen leaf whenever he attempted to raise a cup to his lips. His body, limbs, and head were covered with sores which were only partly hidden by the blood-stained dressings.

His recovery was protracted but complete. The most satisfactory local application was dry bismuth (subnitrate). It was soothing, hæmodynamic, and not easily removed except by intention. It was dusted over the parts by means of a powder gun, and removed not oftener than every other day. Internal treatment consisted of the muriate tincture of iron in small doses three or four times a day (sometimes it could not be tolerated for days together), and occasionally quinine in large doses. In regard to nourishment, the most simple liquid food (for a while Murdock's) only could be borne, and hypernutrition was made impossible on account of the great irritability of the stomach. Those nails which had been the seat of hemorrhage into their beds (before mentioned) lost their vitality, came away, and were replaced by new and healthy ones.

Dr. W. T. Alexander saw the case with me when at its worst, and believes it to have been a case of "acute pemphigus vulgaris" as described by A. R. Robinson.¹ It certainly was a bullous eruption.

¹ "A Manual of Dermatology." New York, Appleton & Co.

BROMIDE OF ARSENIC IN ACNE.

BY

HENRY G. PIFFARD, M.D.

DURING the past two years, I have met with various paragraphs in the press to the effect that bromide of arsenic was a "cure" or "sure cure" for pimples, and crediting the assertion to me. The last of these that has met my eye is taken from the *Medical Age*, and reads as follows:

"BROMIDE OF ARSENIC FOR PIMPLES.—It will be a great relief to suffering thousands to learn, on as good authority as Dr. Piffard, that the bromide of arsenic is 'a cure for pimples. He recommends a one-per-cent solution, of which one or two minims are to be taken in a wine-glassful of water three times a day, on an empty stomach. The dose is to be diminished as the pimples begin to disappear."

I have, in addition, received numerous letters from physicians asking for further information relative to the uses of the drug in question. In reply I can only say that I have never asserted that bromide of arsenic was a cure for pimples, or anything else, and that the only authority for the paragraphs will be found in the following extracts from my published writings:

"The use of bromide of arsenic is, I believe, original; at least, I have not met with any reference to it in literature. Conceiving, from purely theoretical considerations, that it might be useful in certain cases, I first tried it in the spring of 1878 in a case of pustular acne vulgaris of moderate severity, and gave it in doses of one milligram (gr. $\frac{1}{65}$) three times a day. Within a week the patient, a young lady, returned, complaining that her face was much worse. On examination, I found on each side of the face a crop of miliary pustules in addition to the acne. The arsenic was discontinued, and a placebo prescribed. This was followed by improvement for a week, when the arsenic was resumed in much smaller doses, and in three or four weeks the case was substantially well. In a second case I had a similar experience, and in a third case I prescribed an alcoholic solution containing one grain to the ounce, and directed that two drops should be taken night and morning. This patient I did not again see for nearly six months, when she informed me that the medicine had in a few weeks accomplished all that she desired. Since then I have used bromide of arsenic with much satisfaction in pustular acne, but have not tried it in other varieties of this affection, nor in other cutaneous diseases."—*Mat. Med. and Ther. of the Skin*, 1881, p. 28.

"The bromide of arsenic occupies a middle ground between arsenious acid and sulphide of calcium, and is probably adapted to a greater number of cases than the drugs just mentioned."—*Ibid.*, p. 137.

"Next in usefulness is bromide of arsenic, given in doses of from $\frac{1}{100}$ to $\frac{1}{50}$ of a grain. A one-per-cent solution in alcohol is a very available method of dispensing it, and the dose will be one or two minims (not drops) in a wineglass of water two or three times a day. If any gastric irritation should ensue, the dose should be lessened. The repetition of the dose, and the continuance and discontinuance of the drug, are to be governed by the same rules that apply in the case of calx sulphurata. As regards the choice between the two drugs mentioned, I can say but little, other than that it has been my custom to use the former drug in cases of a lymphatic character, and the latter in those of a more florid type."—*JOURN. CUT. AND VEN. DIS.*, March, 1884.

ON THE RELATIONS OF LUPUS VULGARIS TO TUBERCULOSIS.¹

BY

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IN order to arrive at trustworthy conclusions respecting the nature and relations of any disease, it is necessary to study its phenomena from both the clinical and pathological standpoint. In the case of lupus vulgaris, this study has been conducted by those whom we recognize as having brought to the task all due skill, diligence, and conscientiousness. It is none the less needful, however, to compare from time to time the results thus obtained with those acquired by personal experience.

Reviewing the returns collected by the statistical committee of the American Dermatological Association, we find that from the year 1878 to 1884 inclusive, 350 cases of lupus vulgaris came under the observation of members furnishing these returns, of which number 124 cases occurred in private and 226 in public practice. From the accompanying table, showing the number of cases reported from the several districts, it appears that New York is credited with the largest number, viz., 120; Chicago the next, 99, and the other districts, respectively, Boston, 67; St. Louis, 28; Baltimore, 16; Philadelphia, 13; and Canada, 7.

¹ Read at Ninth Annual Meeting of Am. Dermatol. Assoc.

Table of Statistics of Lupus Vulgaris as reported to the American Dermatological Association.

Years.	Boston.	New York.	Philadelphia.	Baltimore.	St. Louis.	Chicago.	Canada.	Priv. Practice.	Pub. Practice.	Total.
1878..	21	3	1	8	2	7	—	13	29	42
1879..	10	6	1	—	3	16	—	16	20	36
1880..	8	22	1	1	5	17	—	20	34	54
1881..	8	13	8	2	6	14	—	15	36	51
1882..	6	24	1	4	6	12	3	26	30	56
1883..	8	34	1	1	—	15	2	15	46	61
1884..	6	18	—	—	6	18	2	19	31	50
7 yrs.	67	120	13	16	28	99	7	124	226	350

It is reasonably certain that these figures, rather than those set opposite the names of several other disorders, furnish a means of arriving at some knowledge of the relative frequency of the disease as tabulated in this country. For, first, lupus vulgaris, being an unusually chronic malady, is one particularly likely at some time or another in its progress to drift from the hands of the general practitioner into the management of the expert; second, its formidable features prompt the average physician at an early period to consult the dermatologist respecting its nature and therapy; and lastly, the poorer class of patients, often failing to secure relief from the very best of treatment, are impelled at one time or another to visit the public charities, where such cases are assigned for treatment to special departments. Briefly, it may be said, that for one case of lupus that chances to escape the eye of the expert, there are hundreds of cases of eczema that never come under his observation. Making due allowance, therefore, for errors of diagnosis and of record, it may be assumed as reasonably certain that the figures given above nearly represent the relative frequency of lupus vulgaris as it exists in this country.

Many of the cases reported from the Chicago district came under my personal observation. Twenty cases only, however, are collated for illustrative purposes in this paper, being those last observed in a strictly consecutive order. In making up the list, it was deemed best to exclude all patients who were exclusively examined at the public clinic, the record being then generally less full than in the case of those observed in private practice, though occasionally, after a first appearance at the clinic, one or more of this class of patients were subsequently examined in private, and their records included in the list. The cases where the diagnosis was doubtful or obscured by co-existence of syphilis are excluded,

save in the few instances where special attention is directed to the reasons for such exception.

As the lesions of *lupus vulgaris* in its several forms are well understood, and have been again and again illustrated by all the devices known to art, the following records include merely the briefest outlines of each case, with special reference to the points in each, throwing light upon the subject under consideration.

CASE I.—A. P., American, male, unmarried, aged 28 years; profession, attorney. Sept. 9, 1881.

This patient had a typical, irregularly circular, orange-sized patch upon the left cheek, involving a part of the lower lid of that side. It was made up of softish tubercles of reddish-brown hue, deeply imbedded in the skin, ulcers, crusts, and cicatrices. It had existed since early life, beginning in the fifth year, but had largely spread during the last decade. Its origin had been referred by his family to a traumatism. It had been treated by repeated cauterizations. There were no venereal antecedents, and his family record contained no history of tuberculosis or struma. He was a man of average stature, weight, and development, complaining chiefly on account of the visual disturbance induced by the irritation starting from the involved lid.

CASE II.—A. R. S., American, male, aged 52 years, but still vigorous, well nourished, and active. Married twenty-seven years, with one married daughter having healthy children, all carefully examined. Two of his children died of infantile disorders.

Nov. 16, 1881, he exhibited a palm-sized patch on the left cheek made up of sub-epidermic tubercles of dark ham-color, an infiltrated, desquamating integument, central irregular cicatrices, and the lobe of the left ear agglutinated to the corresponding part of the cheek. The patient was a man of wealth and position, free from venereal antecedents, and his family record showed no trace of cutaneous disease, tuberculosis, or struma. He was a ship-chandler by occupation, and had led an active life, never having suffered from other malady of consequence. The disease dated from the sixth year of life, beginning with "lumps which burst, and ran, and left scars," one of the latter being still visible near the ear. There was a history of traumatism at that early period, also of another occurring in the twentieth year in the site of the involved patch, which had considerably aggravated it. He had been treated with repeated cauterizations, and the knife had been used once in an effort to remove the diseased patch.

As he improved somewhat under treatment, he was lost sight of till 1883, when he re-appeared with a characteristic, thin-edged, soft-floored, and crusted ulcer centrally situated in his patch of disease, and distinctly surrounded by softish, dark-red tubercles. This was treated by caustic potash and other destructive agents, which failed to induce cicatrization, the patch slowly extending. In 1884, the disease having now lasted nearly half a century and the patient being fifty-five years of age, a marked change occurred in the cheek. It was then the seat of a single ulcer, which, as it spread, destroyed all signs of other disease, and rolled out a thick, everted, glazed, and reddish edge. It was then twice thoroughly curetted and after each operation wellnigh cicatrized, but recurred

after each, presenting finally the typical aspect of a malignant epithelioma. This man is now dying, exhibiting characteristic cancerous cachexia, a gigantic ulcer in the cheek, which has destroyed the larger part of the ear of the left side, a portion of the left eye, the larger part of the malar bone of that side, three-fourths of the lower maxilla, and a corresponding part of the soft parts of the face.

This patient, in an advanced stage of ulceration, was shown by me both to Dr. E. L. Keyes, of New York, and to Dr. L. A. Duhring, of Philadelphia, each of them stating that there was no evidence present of lupous involvement. I have, however, not hesitated to set down this case in the same category with the others, as its early history and features point unmistakably to a disease preceding the epitheliomatous change, lupoid in character, and decidedly less malignant in type than that which followed.

CASE III.—W. B., aged 37 years, married thirteen years, English, male, stationer, with one living child, which was examined and found to be in sound health.

Dec. 15, 1881.—Patient stated that he had been born with the present disease, which is probably, therefore, to be referred to an early period of infancy. It began as a "red spot" under the chin, which constantly spread and troubled him; but since his coming to America, a similar spot appeared on the left buttock, which proved to be greatly annoying in that locality. He had been under the professional care of Mr. Startin, of London, who pronounced his case to be *lupus vulgaris*, and who had given him a paint which he applied with some relief. He admitted having contracted a gonorrhœa in his youth, but no other venereal disorder.

Beneath the chin was a small palm-sized ulcerated and crusted patch, carefully covered with the reddish hairs of the beard. On the left buttock, was a large platter-sized, exulcerated, crusted, thin-edged, only partially cicatrized patch, presenting the same general features recognized in the patch under the chin. There were numbers of tubercles in each which had not broken down. The condition of the patient was most distressing, as he could not occupy, when seated, the usual posture required for that attitude.

The notes of this case are quite full, and supplemented by voluminous letters written after the patient passed from observation. The case is noteworthy on account of the fact that he presented a picture of sound health not often to be recognized in the subjects of this disease. He weighed one hundred and sixty-two pounds, had remarkably florid cheeks, stout muscles, and was able to attend to his business with regularity and success. There was no history of tuberculosis in any member of his family. He was last seen by me Nov. 14, 1882.

CASE IV.—Mrs. L. S., a Jewess, aged 49 years, married twenty-nine years, mother of six children, all healthy, with married daughters, who were themselves mothers of sound children, sought advice May 26, 1881. She stated that she had suffered from the present disease since her earliest recollection in childhood. It had never disappeared, and had slowly increased in severity and extent. She was an enormously fleshy woman, with a huge pendulous belly, which, when she was seated, rested upon the thighs. The entire lower part of this belly and the upper third of the left thigh was the seat of an enormous cicatricial patch, irregularly

marked with depressions and ridges, and limited peripherally on the upper part of the abdominal area and at the edge which encircled the thigh, with a serpiginous ulcer. This was linear in general form, crusted here and there, secreting actively at some points of the ulcerated surface, and tolerably well defined by a narrow border. The ulceration had begun to attack the outer fold of the left labium majus. For years she had sought merely palliative treatment, having had a wide experience of all others. There was no history of struma or tuberculosis in her family record.

CASE V.—W. H., male, unmarried, aged 29 years, resident of Illinois, applied for relief June 6, 1882. There was an egg-sized ulcerated patch in the centre of the left cheek, surrounded by deeply imbedded tubercles, a few having lately broken down on the upper edge. At one point the ulceration had attacked the lower lid of the left side, and the annoyance of this led him to seek aid. The disease had existed from an early period in life; he could not assign an exact date to its origin. This patch was treated by multiple linear scarifications, several times repeated, with decidedly favorable results, evident in the course of two months. After that time he was in charge of his local physician. There was no history of venereal antecedents or of other diseases of gravity; and no trace of tuberculosis or struma in his family record. Parents and two sisters living and in good health, one of the latter examined. He weighed one hundred and fifty-six pounds, was well nourished, and engaged in business.

CASE VI.—N. N., female, aged 38 years, wife of a farmer, married in all sixteen years, having had two husbands without pregnancy occurring. She applied for advice, Aug. 1, 1882.

The disease began in her seventh year on the upper lip and nose, and had gradually extended till the two regions were involved in an irregular ulceration, surrounded by tubercles, and characterized by a thin edge, a softish floor, and a scanty secretion.

She belonged physically to a class of people seen often among the farmers' families of the Western interior. She was thin, sallow, of decidedly nervous temperament, and poorly nourished. But she could give no history of tuberculosis or struma in her family. Her father had been drowned; mother, living, aged sixty-five, and in good health. There were six living brothers and sisters, all reported to be healthy.

CASE VII.—S. E., farmer, aged 28 years, unmarried. Came for advice Sept. 15, 1882. His disease began near the tragus of the left ear on the right side, where was a silver-dollar-sized patch, made up of scar-tissue and ulceration. The lobe of the ear was involved to the extent of three-fourths of its substance; the external auditory meatus was closed by reason of infiltration of tissue. He gave a history of submaxillary adenopathy when a boy, and of some sort of swelling in the region of the shoulder of the same side, which had been, as he reported, "absorbed," without leaving a scar. The hearing distance of the involved ear was reduced to contact with the watch.

The patient was fairly well nourished, gave no history of venereal antecedents or of other disease of consequence; and the family record contained no evidence of tuberculosis or struma. Parents both living and reported well; one only of their five children dead of some infantile disorder.

CASE VIII.—M. P., German, female, unmarried, aged 22 years, presented herself first at the clinic, with an unmarried sister, May 11, 1882. Her disease was reported as having first appeared in early childhood. She exhibited a large palm-sized patch on the right side of the cheek, involving also the entire side of the nose adjacent, made up of ulcers, crusts, tubercles, and centrally situated scars. She gave a very clear family record extending to the grandparents of both sides, without record of tuberculosis or struma. She was a fresh-looking, light-haired, blonde woman, remarkably well nourished, with well developed figure, and presented all evidences of sound health with the exception of her facial disfigurement.

CASE IX.—F. H., a Jewess, 19 years old, came with her parents, May 11, 1883. She had suffered from the present disease, according to the statements of her parents, for only a few years past. She was a thin, pallid, narrow-chested, sallow-faced girl, apparently ill-developed, who had been menstruating four years. Both father and mother were small, sallow-faced representatives of their race; but they reported their two other children as quite healthy, and could give no family record of struma or tuberculosis. The nose of the girl was the seat of an ulceration involving the tip and ale, surrounded by purplish tubercles, some quite prominent; and there was an attempt at scarring only on the right side. The patient returned in the course of the next year, greatly improved in appearance, the sore having completely cicatrized in its entire extent, her weight having increased, her color exhibiting a decided change for the better. She had been treated by iodine, and cod-liver oil internally, with vigorous stimulation of the sore. Father, aged forty-eight years; mother, forty-seven; there had been one miscarriage in the second month of pregnancy, resulting from accident.

CASE X.—M. G., female, aged 42 years, married twenty-one years, sought advice, July 23, 1883. An irregular patch of scars, ulcers, and crusts, was visible on the left cheek and on the side of the nose, as large as a silver dollar. It had existed since the tenth year of life; and had therefore endured for thirty-two years. It had troubled her more since her marriage than before that date, having been decidedly worse since the thirty-first year of her life. She had two living children, reported to be healthy; and two dead, one of diphtheria at the seventh year of age; the other of cholera infantum, in infancy. There had been one miscarriage, the cause of which was unknown. No family record of tuberculosis or of struma.

CASE XI.—G. W. The case of this patient, a male, aged 30 years, is familiar to most dermatologists by reason of the excellent photograph of the patch of disease on his cheek furnished in the admirable collection published by a member of this Association, Dr. George Henry Fox, of New York. It appears in both editions of the atlas¹ referred to.

After placing himself in the charge of several dermatologists of repute, this man presented himself to me once, in 1883, at which time I had the opportunity of making a personal examination. He appeared somewhat older than at the time when his picture had been taken. The disease was unchecked in the cheek, and his general health was rather less fa-

¹ "Photographic Illustrations of Skin Diseases," New York: E. B. Treat, 1879, p. 55.

vorable than before. As the notes of the case are published by Dr. Fox, I merely refer to them in this connection.

CASE XI.—I. J., male, aged 12 years, came from the country in a district near Chicago, Sept. 10, 1883. His parents said that the disease with which he was afflicted had existed from earliest childhood. He was found to present one of the most repulsive pictures of advanced lupus vulgaris. The entire face was converted into a mass of irregularly wasted, crusted, and cicatrized tissue. The palpebral orifices were almost completely closed; the nose was transformed into a wasted and parchment-like projection from the surrounding crusts; and the mouth had become an irregular slit in the middle of the lower segment of the area of defacing crusts and scars. The accompanying photograph conveys some idea of the hideous transformation which the involved surface had undergone. Father, mother, and two living brothers were in good health. There was no history of tuberculosis or struma in the family record.

CASE XII.—C. H. Came originally from the clinic, Nov. 16, 1883. He was 14 years of age, full-faced, well-nourished, and had suffered from his disease since early life. Father, mother, and two sisters were in good health. No history of struma or tuberculosis in the family record. The left leg was the seat of an extensive patch, reaching from below the patella to near the ankle, made up of cicatricial tissue, ulcers of irregular outline, equally irregular scars, tubercles in progress of degeneration, and crusts. One ulcer had involved the periosteum, and produced thickening of the bone. He gave a distinct history of a succession of developing tubercles, which gradually broke down and ulcerated. He was seen in the course of the following year, having been in the interval under the charge of an excellent physician. By judicious treatment, a great improvement had been wrought in his condition, but the disease was still unchecked.

CASE XIII.—M. H., female, aged 24 years, came with a letter from an eminent surgeon who had charge of her case on Nov. 10, 1884. Her grandparents on both sides lived to advanced years; father living and in good health, aged 48 years; mother, the same, in the 44th year. One brother living, aged 22 years, and in sound health. No deaths; no history of disease or deformity in the family record. The disease began in her tenth year and had always troubled her since. She had been married four years, but had never been pregnant. On the right cheek was a patch of disease which had extended gradually up over the brow of the same side, the whole nearly as large as the palm. It reached well up toward the vertex on the upper part of the brow, which she had covered as well as possible with her hair. The disease had been thoroughly treated by active cauterization, and though still ulcerating at points, was for the most part protected by a thin irregular, and somewhat irritable scar. All her functions were properly performed. She weighed one hundred and thirty pounds; was fairly well nourished; and by the aid of her toilet, concealed the deformity so well that she could have passed for a sound woman in society.

CASE XIV.—A. P., male, came for advice, Nov. 12, 1884, aged 41 years, married seventeen years, one healthy living child, aged 13 years. His wife had lost no child, and had never miscarried. He had suffered from a disease since childhood, which both Hebra and Neumann, in Vienna, had pronounced lupus vulgaris. It had existed upon the face,

and had left that part of the body seamed with irregular cicatrices, corded, ribbed, and in the highest degree deforming. There were still faint irregular lines of ulceration and crusting visible on the right temple and brow of the same side. He gave, however, a history of syphilitic chancre and subsequent signs of general lues, incurred four years after his marriage. When examined, the face of the left leg was seen to be covered with typical syphilitic scars, and pigmented areolæ. All of these active manifestations of disease yielded to mercurial treatment.

Although syphilitic, I do not hesitate to place this case in the category of lupus, not merely on account of the eminent men who pronounced him, over their own signatures, the subject of that disease, but also because of the indubitable marks of a disorder, not syphilitic, existing long before such infection. His living child was conceived before that occurrence. The patient could give no history of a malady of any kind in his family. He presented a hideous picture of disease, and weighed merely one-hundred and twenty-one pounds; but his health improved markedly.

CASE XV.—C. W. D., female, aged 36 years, married thirteen years, with no children and one miscarriage at the fifth month, reported to have resulted from an accident, sought advice, Jan. 5, 1885. Her father died of consumption at the 37th year; mother living and in good health, aged 60 years; one brother living, the subject of Pott's disease of the spine, and said to be "scrofulous." She reported that when very young she had "lumps in the neck," that there were traces of her present disease, which, however, did not give her much annoyance till her fifteenth year. At that time the right cheek became involved in a dry patch which persisted and finally ulcerated. It had slowly spread during the last few years. When examined, the seat of the disorder named above, was recognized as involved as in an irregular patch of ulceration, crusts, tubercles, and cicatrization. In size it did not exceed the section of a large orange. The health of this patient was poor, and her functions were irregularly performed. Her nutrition, however, was fully up to the average standard. She weighed one hundred and thirty-three pounds.

CASE XVI.—Miss E. B., unmarried female, aged 35 years, applied for advice, Mar. 11, 1885, with a letter from her physician. Her father was said to have died of softening of the brain at 57 years; mother living, aged 60 and in good health, though occasionally affected with rheumatism. Two sisters living, aged respectively 28 and 30 years, both healthy. She weighed one hundred and seventeen pounds, was well nourished, and gave history of good health save as to the cutaneous disorder which had lasted for twenty-five years.

When examined, the left cheek near the lobe of the ear was found to be the seat of an exceedingly irregular ulcerative process, proceeding in a band-like form from below the malar bone in the direction of the tragus. About it on either side were purplish tubercles, sub-epidermic in situation. The inferior segment of the band-like ulcer had healed with production of an irregular and corded scar. Above the ulceration was progressing with purplish edges and a secretion which produced a crust over the part. The floor of this ulcer was softish and hemorrhagic. She had been treated with active cauterization; and by the same procedure, the entire patch was made to cicatrize in the course

of a few months. There was no record of tuberculosis or of struma in her family.

CASE XVII.—The notes of this case, that of a young girl originally brought to the clinic, in February, 1885, are unfortunately defective, the patient having elicited much sympathy by her wretched condition. She was about 15 years of age, an orphan who could give only the most imperfect history of herself or her family, as she had been an object of charity for years. The entire face was converted into a hideous travesty of the human countenance, being wellnigh completely covered with a skin which had undergone cicatricial atrophy to an extent sufficient to disguise and distort each of its organs. Glistening maculations and striations were commingled everywhere with scales and infiltrated plaques. The nose had the characteristic "worn-away" appearance; the eyes were obscured by unsightly, reddened, and swollen lids; the mouth was a contracted, unyielding slit between the glistening-white cheeks stripped of every vestige of normal tissue. On the shoulders were several palm-sized patches of cicatrized ulcers. There was submaxillary and axillary adenopathy. The picture presented was, in brief, that of extreme advance of the disease in a patient long subjected to the worst possible hygienic conditions. The case is to be classed with but two others in this list, illustrating the ravages of lupus vulgaris in uninterrupted evolution in young patients. As respects more particularly the present inquiry, it is unfortunate that the record of her family history could not be obtained.

CASE XVIII.—E. W., female, aged 24 years, unmarried, native of England, sought advice Sept. 10, 1884. She had suffered from her disease for several years, and had been treated for it by cauterization. It was decidedly the slightest manifestation of the pathological process represented in the list of cases here collated. When examined, the right side of the nose was found to be affected with a disease almost limited to the ala. This was covered with a bluish-white, centrally situated cicatricial spot, surrounded by isolated and confluent rather prominent tubercles, some of which were in the course of exfoliation. In one spot above, as though the progress was toward the root of the nose, there was a characteristic, bean-sized, thin-edged ulcer, having a softish, bluish-red floor. The disease was in this instance arrested by active local treatment.

This patient was in a remarkably sound condition of general health. She had a fair color, weighed one hundred and thirty-six pounds, and was even fleshy. She was accompanied by her brother and mother, both of whom appeared unusually vigorous. The father was living and well; one other brother in the same condition. There were two children dead in infancy of infantile disorders.

CASE XIX.—A. P., male, married, farmer by occupation, German by birth, resident of Illinois, was a hospital patient to whom I was called Feb. 25, 1885. He gave an excellent family record, being himself 60 years old, with grown children and grandchildren. There was no history of struma or tuberculosis in either his ancestors or descendants. He was poorly nourished, weighing but one hundred and thirty-five pounds, having at one time weighed one hundred and eighty pounds.

His disease began in early life about the period of puberty, but had been noticeably severe in the present locality only for thirty years. In his childhood, the face and eyes were said to have suffered more.

When examined, he was found to be almost helpless in consequence

of a severe affection primarily of the skin of both hands and arms, reaching well to the upper third of the forearm on each side and involving one elbow. The tissues here, on both flexor and extensor aspects of the arms, the palmar and dorsal surfaces of the hands, and all parts of the fingers, were the seat of extensive ulcers, scars, softening and exfoliating tubercles, deep and superficial atrophy, osteitis and periosteitis, agglutination of tendons, and deformity. Here and there were nut-sized abscesses. Several of the fingers were semi-flexed, thickened, and retracted upon the dorsum of the hand. He was able to apply and remove dressings by the aid only of the forefinger and thumb of each hand. The fourth finger of the right hand was so much enlarged and retracted that it constituted a serious obstacle to the dressing of the parts, and at his urgent solicitation was removed by amputation. Section of the deepest portion of this amputated organ showed after staining characteristic lupus bacilli, and predominantly distinct nests of epithelium, showing that in this part the lupoid growth had been replaced by an epithelioma, a transformation noted in one other of the cases here collated.

CASE XX.—C. P., female, unmarried, aged 16 years, was sent to me from the Illinois Charitable Eye and Ear Infirmary, June 11, 1885. The larger part of the face below the brows, including the nose, cheeks, lips, lower lids, and a small part of the forehead, was the seat of a diffuse infiltration, irregular in contour, here and there marked by adherent crusts covering shallow ulcers, dark reddish tubercles, extensive atrophic cicatrices, and a puffy appearance of the involved area, as though the pathological process had not yet wholly abandoned the field where scarring and wasting marked its progress. The right palpebral orifice was converted into a circular aperture one-half the normal size, resulting from agglutination of the lids; the left was a similar process changed to an obliquely directed slit. There was barely enough vision left to permit of unaided locomotion in the streets. The nose was represented by a thin, parchment-like projection between the shining, scaling, infiltrated, and puffy cheeks. The nostrils exhibited the common peculiarity of a change in the plane of aperture to a slightly inclined vertical.

She stated that she had suffered from the disease for about ten years, which began to attract attention, therefore, about the sixth year of life, but she declared there were ocular changes preceding the facial and strictly cutaneous disorder.

She was a remarkably well developed and vigorous girl, weighing one hundred and one pounds, with no history of any disease whatever save in the face. She had menstruated regularly for one year. Her father's father, father's mother, mother's father, and four brothers and sisters were all living in good health; and gave no history of disease of any kind. One brother had died in his third year of some infantile disorder, while the mother's mother had died in advanced years of a disease reported to be "neuralgia in the head."

Reviewing the significant facts contained in this clinical record, we find them more remarkable for what is lacking than for what is expressed. Of the twenty cases, eleven occurred in women, and nine in men, the proportion being nearly that stated by other observers. The average age at date of examination was somewhat over thirty years, this period being

unusually advanced on account of the inclusion of the cases of two aged patients who had suffered from the disease for nearly a lifetime. The age at which the earliest manifestations of lupus were noted is set down in but a few instances, and the inferences on this point are thus without value. The reason for this is that the knowledge had by patients of the disease, as it appeared in childhood, is often of a traditional character.

As to the regions affected, in seven cases the cheek was involved; in four, the greater part of the face; in two, the nose; and in one each, the ear, the belly, the chin and buttock, the lip and nose, the forearms and hands, and the leg.

More significant is the family report represented by these cases. Of the relatives of the subjects of the disease, there were living and in sound health seven grandparents, fifteen parents, twenty-six brothers and sisters, thirteen children, and four grandchildren. Of the dead, the record is singularly defective in point of association with cachectic disorders. One parent only is stated to have died of phthisis; one was drowned; one reported as suffering from "softening of the brain." One grandparent is reported dead of "neuralgia." One brother was said to be suffering from Pott's disease of the spine. One child died of diphtheria; one of cholera infantum; others of the disorders of infancy, which could not be described. In two cases there is no family record of any kind.

Of the two patients referred to above, as attaining advanced age, it may be remarked that each eventually suffered from an epithelioma originating in the lupus tissue. It seems probable that when lupus vulgaris persists to the fiftieth or sixtieth year of life, it either undergoes a species of involution, the disease no longer extending as in the earlier ages, or it undergoes an epitheliomatous transformation. A very full bibliography of papers touching upon this point is appended to an interesting monograph on *Lupus Karcinom* by Dr. Jos. Schütz.¹

The description of the appearance of an epithelioma resulting from such lupus transformation in the cheek, given very graphically by Hebra, might almost serve for a portrait of one of the cases here collated.

One of the patients described above was without question the victim of a syphilis incurred years after he had been treated by two eminent German dermatologists for lupus of the face.

If the statistics of the dermatological clinic, which I have held weekly for years in the city of Chicago, be compared with the facts and figures described above, I am quite confident that the conclusions will be very nearly those just stated. Special attention has been given to this point in the examination of every lupus patient, the questioning having been conducted in public, in the presence of many students and practitioners.

¹ *Monatsschrift f. prakt. Derm.*, Bd. iv., No. 3, März, 1885, p. 74.

With every effort to throw light upon this question, no patient has ever been presented at this clinic, suffering from coincidence of lupus vulgaris and unmistakable tuberculosis of the lungs. Numbers of the subjects of the disease last named are constantly applying to the proper department of the dispensary for relief, and any instances of lupus vulgaris among them would be assigned at once to the dermatological clinic. Further, no clear record has been given by any of these patients examined in public of the existence of tuberculosis or struma in any branch of the family.

Yet such records in other cases are constantly accumulating. For example, a young girl lately applied for relief of an eruption that was recognized as a dermatitis medicamentosa induced by arsenic given internally for relief of some systemic trouble. It was noticed that she limped and wore a brace over the left ankle. When questioned, she reported that that joint had been diseased for many years; that her father and four other members of her family had died of phthisis, and that a living sister was suffering from the same disease.

(To be continued.)

AMERICAN DERMATOLOGICAL ASSOCIATION.

NINTH ANNUAL MEETING, HELD AUGUST 26, 27 AND 28, 1885.

Official Report of the Proceedings by the Secretary.

(Concluded from p. 318.)

DR. TILDEN then read a paper on

“MYCOSIS FONGOÏDE.”

It described the case of a man, twenty-eight years of age, who, having been in good health until his twenty-fifth year, was then, for the first time, aware of the appearance upon his elbows of several small red and desquamating spots which were attended with pruritus, affecting principally the outer sides of the arms. There were no further manifestations of cutaneous disease for several months, at the end of which time there appeared irregularly distributed upon the face, abdomen, and arms, erythematous spots and patches of various sizes and individually of a fugitive nature, accompanied by pruritus, which was the only subjective symptom of which the patient complained. According to his statement, these cutaneous lesions always retained their dry and scaly character, and were never accompanied by anything like the formation of vesicles.

With temporary variations in severity, these changes in the skin con-

tinned for about a year and a half, attended with pruritus, but unaccompanied by any change in the previous good health of the patient. At the end of this time, and for the first time, there appeared several small, red cutaneous nodules upon the left cheek and throat. Some of these nodules spontaneously disappeared, and no others showed themselves, when there appeared upon the right thigh a small papule which slowly increased in size until it formed a tumor the size of an orange, the upper surface of which was deprived of epidermis. From the pathological tissue thus exposed there exuded a thin, reddish fluid, which dried to a thin crust. The appearance of this papule was followed during the succeeding year of the disease by the development in many parts of the body, more particularly the axillæ, groins, neck, and scalp, of similar papules, many of which had developed into tubercles the size of a filbert, and several into tumors as large or larger than a hen's egg. These lesions were at first of moderately firm consistence, and covered with smooth, pale-red epidermis, being circumscribed and rounded elevations. Under conditions of fusion and coalition of these nodules, were formed irregularly outlined, uneven, and sometimes fissured, infiltrated patches of a darker, more brownish, or bluish-red color than the original and isolated lesions, and covered for the most part with epidermis, being only here and there excoriated and oozing. Several of the larger tumors reached a stage in their evolution at which began a sluggish involution or retrograde change, manifested by the disappearance of the epidermis which covered them, thus representing the typical moist fungous excrescences of *mycosis fungoides*.

In spite of this superficial erosion, the tumors affected by it preserved their size and shape for a long time. The excoriated tumors were firm in consistence, but several, which were still covered with epidermis, more particularly those upon the head, were so soft as to suggest fluid or semi-fluid contents. There were in none of these lesions any evidence of the formation of pus, or any deeply destructive ulceration. There was severe and general pruritus, but the general health of the patient was fair, the chief subjective symptoms, besides the itching, being a feeling of weakness and shortness of breath upon exertion. There was evident anæmia, and the heart presented a systolic murmur, but physical examination failed to detect anything out of the way, except indolent and painless enlargement of many of the accessible lymphatic glands.

The patient remained under observation for three months, during which time there took place development of fresh papules from previously existing erythematous spots. The last time he was seen, one of the largest tumors had entirely disappeared, and its original site was covered with epidermis, while the largest tumor of all had diminished in size by nearly one-third, without the manifestation of any quickly destructive

ulceration. During the last four months the patient was not seen, but his death about three years and eight months after the beginning of the disease became indirectly known to Dr. Tilden. Two of the small nodules were excised and given to Dr. Gannett, pathologist to the Boston City Hospital, for examination, whose report showed them to consist of the new formation of cytogenous or lymphoid tissue in the corium, characterized by the presence of a fine network of connective-tissue fibres, anastomosing to form spaces of nearly circular shape, which contained round cells resembling leucocytes in appearance, the presence of which network in the new growths of mycosis fungoïde was originally described by Ranvier.

DISCUSSION.

DR. WHITE stated that he saw the patient towards the end of his life, and had observed the same wonderful changes as had been described in the growths, many of them gradually disappearing. During the last four or five months of his life, the patient had been given arsenic, under the supposition that the disease might be sarcoma. (Arsenic had been found to render great service in two cases of this disease; one reported by Köbner, and one which occurred in Boston.) Dr. Tilden's patient improved decidedly under the use of this drug. His death was due to a sudden attack of diarrhœa. He (Dr. W.) had no opinion to offer as to the nature of the disease. He saw no reason why multiple sarcoma could not terminate in this affection. No autopsy was made in the case.

DR. ROHÉ had seen a case similar to the one described. He then thought it sarcoma.

DR. FOX had seen one or two similar cases in New York. If he had one to treat, he would try the effects of chaulmoogra oil.

DR. HARDAWAY alluded to a case of pigmented sarcoma which he had reported four or five years ago. The man was still alive.

DR. WHITE said that he had seen a case which had been regarded as one of "remarkable syphilis," and had found it to be an instance of the affection under discussion.

DR. DUHRING spoke of a case of the disease which he had described. In it lesions of the wall of the bladder were found after death. At present he would consider the disease as closely allied to sarcoma. He thought that the differences between well-recognized forms of sarcoma were as great as between sarcoma and mycosis fungoïde.

DR. HEITZMAN said that the histologist who had examined the specimen had described a myxo-sarcoma, and he was unable to understand how he had reached the conclusion that the disease was not a sarcoma. The clinical history, and the description given of the case, fitted myxo-sarcoma exactly, and he saw no valid reason for the use of the term "mycosis." He thought it a plain case of sarcoma.

DR. SHERWELL spoke of a case of melano-sarcoma, where there were many pedunculated and flattened tumors on the body and leg. The patient was vigorously treated with arsenic and mercurials, and is now almost free from the disease.

DR. HARDAWAY asked Dr. Heitzman if microscopical differences

would account for differences in the clinical course of the various sarcomata?

DR. HEITZMAN said that since Billroth had described alveolar sarcoma, it had been recognized as a less malignant affection than myxoma or fibro-sarcoma. Billroth had, it was true, afterwards withdrawn his statement that it was a form of sarcoma and had called it cancer, but he (H.) was still of the opinion that it was a variety of sarcoma.

DR. TILDEN said that patients with this disease generally die of exhaustion, often with diarrhoea, but presenting no internal lesions to account for death. He had chosen the name mycosis fungoides because he knew no better one. He was confident that it was neither sarcoma nor lymphoma. Its clinical course was not at all like that of ordinary multiple sarcoma, as described in writings on the subject; particularly as regarded the rapid spontaneous involution of many of the lesions.

DR. WHITE said that sarcomata might also disappear under arsenic by hundreds, and, as he had seen in one case, in which as many as two hundred tumors thus disappeared, stay away two years.

After studying the microscopical specimens exhibited by Dr. Tilden, DR. HEITZMAN pronounced the case to be, not one of myxo-sarcoma, as he had supposed it to be, but of lympho-sarcoma.

DR. DENSLOW then read a paper on

THE TREATMENT OF ACNE BY THE USE OF SOUNDS IN THE URETHRA.

He prefaced his remarks by a brief review of the cases of contracted meatus reported by Dr. Otis. He then gave an account of a number of cases coming under his observation, in which there were reflex conditions associated with such conditions of the urethra as contracted meatus, stricture, and excessive sensitiveness of the prostatic urethra. In these cases removal of the urethral trouble produced an alleviation or cure of the affection to which attention had been directed. He also reported four cases in which the same treatment was followed by marked improvement or cure of the skin disease (acne).

DISCUSSION.

DR. HYDE desired to call attention to a fact bearing upon the subject discussed in the paper, viz., that many patients with urethral troubles were in the habit of taking internal remedies without the knowledge of the physician, which might, he thought, often excite acne medicamentosa, or they might be taking drugs secretly for sexual hypochondriasis, under the belief that they had blood-poisoning. He would ask Dr. Denslow, in treating cases of acne with sounds in the future, to ascertain how many of the patients had been taking drugs, and how many stopped using them at about the time the acne improved.

DR. DENSLOW said that in none of the patients whose cases he reported was the acne due to drugs, and none of them were in the habit of masturbation. He had no theory of the etiology of acne to advance, but had in his paper simply reported a small number of facts which he had observed since January.

Third Day.

DR. HEITZMAN made some

REMARKS ON ELECTROLYSIS AND OTHER PRACTICAL TOPICS.

He recommended for the electrolytic destruction of the papillæ of hairs, in cases of superfluous hairs on ladies' faces, the Leclanché battery, consisting of six large cells (each over 12" in height) united to one circuit. The advantages of this battery are: it is painless, even the most sensitive person can stand it without inconvenience; the reaction following the introduction of the needle is slight, passing away in a few hours; no pustule and no scar would follow; it is in steady action for at least half a year. Perhaps the failures to destroy the roots of hairs occur more frequently than with the more powerful chromic acid battery. In some cases it happens that a number of downy hairs, after the removal of large hairs, grow up to a large size very quickly, which, perhaps, is due to the carrying of cast-off nutritive material to the fine hairs.

He exhibited a needle-holder, manufactured by Leiter, of Vienna, offering the advantage that the depth to which the needle is introduced could be accurately measured.

Stronger and painful currents had in his hands proved highly satisfactory for the destruction of dilated blood-vessels in the face, the last remnants of rosacea. Less favorable results were obtained in the destruction of flat angioma-spots, so-called port-wine marks. Some cases could be reduced in the tint of their color, others made to disappear, but sometimes after a few months all improvement disappears, and the angioma looks as bad as ever. Trials with the alcoholic solution of sodium æthyl proved that this caustic is in no way superior to nitric acid, and that it is prone to produce scars if brought to bear upon the skin for any length of time, the same as is nitric acid. He described a case of a pale spot on the left cheek of a lady over forty, which was two inches in diameter, dark purple-red and sharply circumscribed, evidently caused by a vasomotor (sympathetic) paralysis. In this case even strong electrolytic currents proved to be of no avail.

The speaker then summed up the results of two hundred cases of falling of the hairs caused by seborrhœa, where he applied the tar-pomatum recommended by him in 1876 (10 to 20 p. c. ol. rusci crud. in vaseline and paraffin, the smell of the tar being nearly destroyed by means of fragrant oils). 12 p. c. of these cases proved to be failures: in a double percentage, the improvement was but temporary; in a limited number the favorable result was lasting. He considers this pomatum a valuable remedy, always to be tried in suitable cases, alternately with sulphur and white precipitate ointments.

He recommended for the removal of freckles an ointment, the formula

of which was given him by Prof. Wertheim in Vienna. The ointment is hydrarg. ammon. muriat., grams 3.75; magister. bismuth, 3.5; unguent. glycerini, 30.; to be applied only every other night.

DISCUSSION.

Dr. WHITE said that he thought the fact that Dr. Heitzman obtained no better results from electrolysis was owing to the circumstance that his current was not strong enough, not causing pain. He himself did not anticipate that more than one hair in ten would return; on the upper lip, not more than one in twenty; whereas Dr. H. expected three or four in the same number to grow again. He himself always produced some pain in operating. He was accustomed to use a chloride of silver battery, which had the advantage of requiring to be filled only once a year. It contained twelve cells, of which he used from six to ten, rarely the whole number. He was accustomed to tell patients that on the chin and neck only one hair in four could be permanently destroyed. He thought the needle-holder exhibited by Dr. Heitzman too short by half, and preferred one the length and size of an unshortened lead-pencil. He did not consider the shoulder or guard necessary, believing that the educated touch was sufficient to regulate the depth of penetration. He used on all parts of the face, except the upper lip, the common steel broach of very small size. Such a needle could be easily bent, and was almost indestructible. He had used one for thirteen months one hour daily; on the upper lip he preferred to use the irido-platinum needle, which is made extremely fine. He thought the cosmetic effect was in proportion to the smallness of the needle used.

As regarded the treatment of seborrhœa of the scalp, he always gave a favorable prognosis in the case of females, an unfavorable one to males. He, too, liked the effects of tar, but thought the odor and nastiness of the drug objectionable. He now used salicylic acid and sulphur, as recommended by Unna, with very good results.

Dr. HYDE, alluding to the statement of Dr. Heitzman, that the nutritive material destined for the large thick hairs was diverted to the downy hairs after the removal of the former, said that in the case of a patient with long black hairs on the chin, if the operation is done, the hairs return and the operation is repeated. Thus an excessive hyperæmia is excited, leading often to urticaria, papulation, or pustulation, and conditions favorable to the growth of hairs. The down grew into coarse dark hairs.

He thought that great injustice had been done the American operation in the last volume of Ziemssen's *Cyclopædia*, in which it was stated that fifty per cent of the hairs returned after removal.

He indorsed what Dr. White had said about the uselessness of a guard on the needle-holder, and preferred the steel broach or irido-platinum needle to anything he had ever seen for the removal of hairs. He had used the rectified *oleum rusci* and thought highly of it, and was surprised to learn that Dr. Heitzman thought so little of it.

Dr. ROHÉ used the McIntosh, a bichromate battery with small cells. He rarely used more than ten or twelve. He had found that the Leclanché cells soon wore out, and being open circuit cells they had to stand a long time to recover.

DR. FOX said that any battery producing a good electro-motive force was good for electrolysis, and that keeping the connections bright and clean was far more important than the choice of any particular battery. In the treatment of naevi, he was in the habit of applying nitric acid in the form of small dots a quarter to a half inch apart. He also liked the effect of the passage of a galvano-cautery instrument quickly over the skin. This caused contraction of the vessels and left no scars.

He thought that, in electrolysis for the removal of hairs, if the needle were carefully inserted and no traction made, the hair would not return. In his experience about one per cent returned. He thought that in some exceptional cases there was a tendency to the constant growth of downy hairs. In other cases, where this tendency is no longer present, the result of treatment is better. He did not accept Dr. Heitzman's theory that the extra nutrition left after removal of large hairs went to the downy ones, nor did he think that the hyperæmia produced by the operation stimulated the growth of the remaining hairs.

He thought that the general results of the operation were good, and spoke of one case in which he removed eight thousand hairs, the face being now practically free from hair and had been for three years. The marks left by the operation were exceedingly slight. The choice of holder and needle was a matter solely of personal preference. He was surprised at the success obtained by Dr. Heitzman from the use of the ointment whose formula he had given, and would expect them to reappear after a time.

DR. ROBINSON had used a similar salve for years, and had found that it had a temporary good effect, making the skin clear and rendering the pigment less visible. He thought that chronic hyperæmia did increase the growth of hair, as shown by the fact that over fractures, and sometimes after eczema, the hairs grow more abundantly than on other parts. He used electrolysis only in those cases where there were a few large hairs, not those in which they were abundant and of all kinds.

DR. WHITE thought that after the operation the lanugo hairs simply grew on but were not stimulated by the operation, simply becoming more prominent because the large hairs had been removed.

DR. HARDAWAY said that he had been doing this operation for the past eight or ten years and thought very highly of it. He was glad to hear that Dr. Heitzman's views of it had changed, and that he now admitted that it was a true electrolysis and no galvano-cautery.

He liked to use a heavy holder, so that the needle would pass in by its own weight, thus avoiding perforation of the follicle-wall. The irido-platinum needle, which was first suggested by Piffard, had the advantage of bending like a bougie and following the course of the canal. He used the MacIntosh battery, and found it a very good one. He thought that much less scarring would follow the operation if the needle were coated up to a certain point so as to make the destruction subcutaneous.

He often told patients that the downy hairs would become visible after the large ones were removed. He knew that the operation was often a complete and radical success, the hairs never returning. His first case was that of a bearded woman, whom he treated about twelve years ago. She is now practically relieved from her disfigurement, although many scars were present he would admit.

He thought a point of great importance was to use hot water three or

four times a day after the operation, and another was to make the operations far apart, at least once a week, to allow the skin time to recuperate. He had tried cocaine to relieve the pain, but had never seen it do any good in this way. He thought it was important to leave the hairs in situ until the electrolytic action was complete, and then to pull very cautiously. The expert touch would of course tell when the follicle was reached, but he had often noticed that the sebum would froth out before the connection was made, showing that the follicle was entered.

He regarded the use of electrolysis as a valuable means of getting rid of freckles, particularly the large dark ones, dotting them with a stiff needle. The best drug for their cure was in his opinion sulphur.

DR. ROHÉ had noticed the frothing when the needle entered the follicle, and had found the reason to be an accidental defective connection prematurely made.

DR. HEITZMAN said that in his experience one hair in four will return on the upper lip and neck, and one in ten on the chin. He did not think that personal skill had much to do with the success or failure of the operation. Hairs were often spiral or corkscrew-like, and the papillæ could not of course be reached.

He thought there was only one test for good *oleum rusci crudum*, and that was to mix the specimen with three parts of alcohol, put it on the finger, and if it dried in a few minutes it was good. The rectified oil dries more slowly and leaves a black mark. He had found that the remedy only did good in baldness, when *seborrhœa* was the cause of the trouble.

DR. TAYLOR then read a paper

ON SYPHILITIC REINFECTION.

He first referred to the literature of the subject, and gave a brief review of the authentic cases on record, giving the names of the reporters. The number of cases previously reported is between thirty and forty. To these he added the histories of three more. A fourth case has been observed by him, but, as the complete history was not prepared, it was not given.

DISCUSSION.

DR. HYDE thanked Dr. Taylor for so valuable a contribution to our knowledge of this rare occurrence. He himself had seen only two cases of reinfection, many others which at first were thought to be of this nature proving to be simply relapsing indurations.

DR. STELWAGON then read a paper entitled:

“OBSERVATIONS ON THE OLEATES IN SKIN DISEASE.”

In it he regretted the lack of reliable observation concerning the action of the oleate preparations. His personal experience, somewhat extended, had placed in question their therapeutical importance. The oleate of mercury, oleate of lead, oleate of zinc, and oleate of bismuth in

his judgment were the only oleates that had proven of service. The oleate of mercury in inunction treatment of syphilis is not comparable to the blue ointment; in fact, the ready absorbability of the former mercurial is questioned, the writer's clinical observation in this respect being in accord with the experiments made by Dr. Brubaker, of Philadelphia, to determine the same question. The oleate of mercury, in the form of a twenty-five per cent ointment, is especially valuable in the treatment of ringworm of the scalp, and the same, or a somewhat weaker ointment equally efficacious in tinea sycosis. He had found oleate of copper of very little value. The oleate of lead melted with an equal part or more, dependent upon the season, of lard, forms a soothing and astringent ointment, an efficient substitute for diachylon ointment. Oleate of zinc, in ointment, compared to oxide of zinc, is more astringent and stimulating, but more apt to disagree as a dusting powder, the conclusion reached was that it is impracticable, as in the presence of heat and moisture (that of the skin sufficient) it becomes sticky. The oleate of bismuth, with lard, or alone, forms a soothing ointment.

In view of the difficulty of securing good preparations, the disagreeable oleic acid odor, the costliness, the frequency of unlooked-for irritating effects and other disadvantages, the writer concluded that the oleate of mercury is the only preparation which promises to hold a permanent value, and even that recedes from its importance of a few years ago.

In regard to the chemistry and preparation of the various oleates, both as to their manufacture by the direct combination of the acid with the base and by double decomposition, almost, if not entirely, as much can be found in the English translation of Gmelin's "Handbook of Chemistry," published in 1866, as in the writings of the past several years.

DISCUSSION.

DR. TILDEN thought the oleates of but little value, and that the oleate of mercury was not so good as blue ointment.

DR. WIGGLESWORTH believed that the only value of the oleate of mercury was as a parasiticide.

DR. DUHRING coincided with the conclusions of the reader of the paper. A few years ago, he was treating forty or fifty cases of ringworm, and used large quantities of a pure preparation of the oleate of copper, gave it a faithful test, but found it had no influence on the disease, which continued to spread. There were no cases of recent ringworm among the number. The drug was also very unpleasant to apply to the skin.

DR. HEITZMAN had found that the oleate of copper did good only in the acute stage of ringworm.

DR. FOX said that in his experience vaseline was much more readily absorbed by the skin than oleates or animal oils. Vaseline he thought the most soothing of all applications, and he had made careful observations.

DR. SHERWELL had not used oleate of copper. He had used the five-per-cent oleate of mercury, which was a very unstable compound. This he had found to do good in even a very weak mixture. As regarded vaseline, he detested it, and thought it almost an irritant. He much preferred cold cream for soothing purposes.

DR. TAYLOR also regarded vaseline as an irritant. The unperfumed white vaseline was less so than the brown, but cosmoline he thought better than either.

DR. WHITE had tried oleate of copper several times as a parasiticide, but without success.

DR. HARDAWAY had used oleates, but had now discarded them entirely. He had had some success with oleate of copper as a parasiticide.

DR. DENSLOW then read a paper on

A CASE OF SYPHILITIC APHASIA AND PARAPLEGIA FOLLOWED BY DEATH,
WITH AN ACCOUNT OF THE AUTOPSY.

About two months before, the patient, a middle-aged man, was first seen, he was attacked by a severe headache, much worse at night. He was found to have alopecia, and a papular eruption most marked about the face and scalp. He had had a sore on the penis a few months before. He was then given iodide of potassium in increasing doses, up to half an ounce daily, and croton chloral. At the end of two weeks he was free from pain. The pain returned two weeks later, and he was again ordered large doses of iodide. By mistake he took drachm doses every two hours, which upset his stomach, but failed to relieve the pain.

When first seen by Dr. Denslow, he was unable to speak or to comprehend questions, and was paraplegic. He sank rapidly and soon died.

On autopsy, the dura mater along the superior longitudinal sinus was found to be thickened and adherent to the pia mater. On the external surface of the pia there were numerous small gummata or cheesy-like masses about the size of millet seeds; these were situated mostly along the right border of the superior longitudinal sinus, extending down to the upper extremity of the fissure of Sylvius. Both the dura and the pia mater showed signs of simple acute inflammatory changes in the regions covered by the masses. The ventricles and interior of the brain showed no pathological changes.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

156TH REGULAR MEETING, SEPTEMBER 22D, 1885.

DR. W. T. ALEXANDER, *President, in the Chair.*

DR. FOX presented a case of

LICHEN RUBER.

W. L., 2 years and 9 months old. A scaly eruption made its appearance on the knees and elbows, a few months after birth, and has remained there ever since. There has been an eruption around the umbilicus and on the neck, but it has disappeared from these locations.

Now a greater part of the skin from the hips to the ankles is covered with a large infiltrated patch, yellowish-red in color. The surface is dry and harsh, and presents a mealy condition, but there are no scales that can be removed. Toward the ankles the patches have a scalloped border, with a few outlying guttate spots. On the healthy skin above the ankle the follicles present the appearance of minute black points, which the mother says are the precursors of the eruption. There is an eruption on the arms similar to that on the lower extremities, the extensor surfaces being most affected. There are small pin-head follicular elevations of a dull color, many being surmounted by a fine scale. The scalp is dry and harsh, but there is a good growth of flaxen hair. The bends of the elbows and popliteal spaces are free from eruption. The skin of the whole surface is somewhat thickened and slightly reddened.

In showing the case, Dr. Fox said that it presented many of the features of the case of lichen ruber occurring in a French boy, and which was shown at a meeting of the Society four or five years ago. In that case, there was a peculiar wrinkled appearance of the skin, and many papules covered with small scales. Both cases presented many of the appearances seen in the disease described by Jonathan Hutchinson as lichen psoriasis.

DR. BULKLEY said that he saw the lesion soon after it made its appearance, and because of the dryness of the skin, the scaliness, and also because it occurred shortly after birth, he called it ichthyosis neonatorum.

DR. ALEXANDER asked what treatment had been employed.

DR. FOX said that he had only seen the case recently, and continued the former treatment, viz., inunction of oil.

DR. ROBINSON presented a case of

XANTHOMA OF THE ELBOWS.

The patient, a woman about 40 years old, had a large patch of xanthoma on both elbows, and nowhere else on the body. In addition, there was some obstruction of the sweat ducts of the face. Patient never had jaundice. She suffered considerably from catarrhal dyspepsia.

DR. PIFFARD said that it was the first time that he had seen xanthoma on the body only, and not on the face as well.

DR. BULKLEY said that it was undoubtedly rare to find xanthoma on the body only, but he had seen quite a number of such cases.

DR. ROBINSON said that he also wished to call attention to the obstruction of the sweat ducts on the face. Many of the single lesions last two or three weeks, or even months. He would classify the latter lesion under the head of sudamina.

DR. FOX showed a case of

FOLLICULAR ECZEMA.

The patient a man, 35 years of age, has had an eczema off and on for the past three or four years. The present eruption appeared a year ago, following a severe eczema of the genitals and thighs.

Now the lesions are situated on the outer aspect of the lower extremities, involving nearly all the legs. The lesions are papulo-pustular and mainly confluent, shading off into discrete papules and pustules. Around the ulnar side of the wrist are a few small papules. The follicles are involved, and where the eruption has remained longest there are numerous horny masses, each surrounded by a brownish-red areola. These horny projections appear at a distance like minute scales; they can be dug out of the follicular openings, slight hemorrhage resulting. On passing the hand over the surface, a shotty feeling is perceived; a few deep-seated lumps are to be felt, similar to an acne induration. The pustules are chiefly small, flattened, and projecting above the surface, almost every one being pierced by a fine hair.

DR. KEYES said that he had seen a similar case occurring in a stoker in Paris. The case just shown presented many of the appearances of an acne.

DR. ROBINSON said that he had been of late studying many cases like the one presented. He believed it to be a peri-folliculitis, or a follicular eczema. The lesions are generally diffuse, and found especially on the extremities. In nearly all the cases there is some intestinal disorder present.

DR. BRONSON agreed in the main with Dr. Robinson; it seemed to him to be analogous to eczema, but there was only a slight difference between this case and a sycois. He would call the lesion follicular eczema.

DR. BULKLEY regarded it as a deep-seated impetiginous eczema. He would give anti-syphilitic treatment, as he had often obtained benefit from its use in chronic cases of eczema.

DR. PIFFARD thought the case to be essentially an eczema running down into the follicles. He would epilate and give large doses of sulphide of calcium.

DR. MORROW then presented a case of

PSORIASIS PALMARIS,

in a man about 25 years old. The patient had a guttate psoriasis scattered over the body, and there were numerous small and characteristic lesions in both palms. He showed the case because some of the members had questioned whether psoriasis ever occurred on the palms.

DR. KEYES believed the case to be one of psoriasis, and that there were no evidences of syphilis.

DR. BRONSON could see no signs of syphilis. He said that in the last edition of Neumann's plates two or three cases of psoriasis palmaris were portrayed, similar to this one.

DR. BULKLEY said he had never seen a psoriasis of the palms in which there were so many minute points of eruption as in this case; to his mind there were evidences of syphilis.

DR. MORROW said that he had a patient in Charity Hospital, in whom a psoriasis had developed twice under his observation. There were numerous minute psoriatic lesions on the palms presenting appearances similar if not identical with the case shown.

Selections.

THE PATHOGENESIS OF CERTAIN AFFECTIONS OF THE SKIN.¹

"Diseased nature oftentimes breaks forth in strange eruptions."

It is well known that the introduction of various drugs into the stomach is sometimes followed by the appearance of a cutaneous eruption, and that the connection between them is one of cause and effect. One of the most common of the so-called medicinal eruptions, consisting of the acneform, pustular, and sometimes furuncular lesions due to the administration of the iodide or bromide of potassium, has been attributed to direct irritation of the glands of the skin because of the attempted cutaneous elimination of the drug from the system, and the detection of iodine and bromine in the pus obtained from the cutaneous lesions gives to this idea apparent support. The histological character of such lesions, however, according to Duckworth, does not indicate that the cutaneous glands are primarily involved, while more recent microscopic investigation shows that, although lesions caused by the internal use of iodine and bromine preparations may originate in dilatation and cellular infiltration of the capillary network which surrounds the sebaceous glands, the same process also affects blood-vessels which have nothing to do with the glandular apparatus of the skin, and may develop to such an extent that the consequent lesions represent a pustular dermatitis. The attribute of an eliminative pathogenesis, therefore, cannot be given to this variety of eruption until more evidence in its favor is forthcoming, although the occasional inception of the process in the neighborhood of the cutaneous glands is suggestive of the ancient maxim, *ubi irritatio, ibi affluxus*.

Other forms of cutaneous lesions may also arise from the internal use of iodine and bromine compounds, and offer for consideration a large class of medicinal eruptions which differ in appearance from those just mentioned, and are independent of the physiological or therapeutic action of the drug to which they are due. They may be caused by many different drugs, and present a variety of forms, the most common and well recognized of which are as follows:

(1) Simple and evanescent erythematous patches, unattended by constitutional disturbance, and not apt to be followed by desquamation, which have been observed after the use of quinine, antipyrine, copaiba, iodide and bromide of potassium, cubebs, and benzoate of soda.

(2) Papular erythematous lesions, attended with exudation into the cutaneous tissues, and resembling in some cases measles, in others the various forms of erythema multiforme, have been produced by the ingestion of quinine, antipyrine, copaiba, and iodide of potassium.

(3) A diffuse form of erythematous dermatitis, not unfrequently accompanied by constitutional derangement, generally followed by desquamation, and often closely simulating the rash of scarlet fever, has occurred in consequence of the administration of salicylic acid, quinine, opium, morphia, and iodide of potassium.

(4) An urticarial eruption, consisting of wheals, is the most common of the medicinal eruptions, is apt to be combined with other forms and attended with constitutional disturbance, and has been described as following the use of co-

¹ Read before the Massachusetts Medical Society, June 9, 1885, and recommended for publication by the Society.

paiba, quinine, salicylic acid, antipyrine, iodide and bromide of potassium, opium, morphia, chloral hydrate, and arsenic.

(5) Purpuric eruptions, or circumscribed exudation of blood into the dermal tissues, sometimes accompanied by hæmorrhages from the mucous membranes, are reported as having occurred from the use of quinine, salicylic acid, iodide of potassium, and chloral hydrate.

Much less common than the above are:

(1) Bullous or pemphigoid eruptions. Such cutaneous lesions occurring after the use of iodide of potassium are rare, but well recognized, and isolated instances of the same are recorded as taking place after the use of bromide of potassium and copaiba.

(2) Vesicular eruptions resembling eczema have been described as following the use of various drugs, but they are exceptional, and the details with regard to them are meagre.

Attacks of typical herpes zoster are described by Hutchinson and others as occurring during the administration of arsenic, but it is a question whether such eruptions are not to be regarded as coincidences rather than consequent phenomena.

(3) A scaly eruption, resembling psoriasis, is mentioned by Gower as appearing, in three cases, during the administration of borax.

The drugs which are most apt to excite cutaneous eruptions, when given internally, are quinine, salicylic acid, copaiba, preparations of iodine and bromine, and it is worthy of notice that the new remedy, antipyrine, is especially prone to give rise to cutaneous manifestations, being followed by them, according to one observer, in ten per cent of the cases in which it is used. Contrary to the opinion of Besnier, who supposed them to be due to reflex nervous disturbance, caused by gastric irritation, these eruptions may ensue whether the drugs which excite them are introduced into the system by way of the stomach, by absorption through the mucous membrane of the rectum, by subcutaneous injection, or by contact with a wounded surface. They make their appearance shortly after the absorption of the drug has taken place, are acute, and run a rapid course in comparison with the pustular dermatitis due to iodine and bromine; are not unfrequently ushered in by a chill and accompanied by vomiting, headache, and fever, offering a temporary but striking likeness to the acute exanthemata; are aggravated by the continuance or increase in the dose of the drug which causes them, and disappear upon its disuse. In some cases, however, the system seems to acquire a tolerance of the drug, and the cutaneous and other symptoms disappear, notwithstanding its continued administration.

The pathogenesis of the medicinal eruptions is of importance as throwing light upon other and analogous pathological processes, but its nature is too complicated, and our knowledge too limited, to permit any such syllogistic and sweeping assertion of its neurotic character as has recently been made in the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES.

With regard to the pustular lesions so often caused by the use of iodine and bromine compounds, the evidence, taken for what it is worth, indicates that the changes in the skin are due to direct irritation of its tissues, on account of the presence therein of iodine and bromine, two very irritating substances. The deposition of finely divided metallic silver in the corium, and consequent discoloration of the skin, which sometimes follows the long-continued administration of nitrate of silver, demonstrates the possibility of the accumulation of a drug in the cutaneous tissues after its internal use, while the typical inflammatory

and suppurative character of the lesions in question suggests reaction to direct irritation, and the detection of iodine and bromine furnishes the material for such irritation. In most cases these inflammatory changes in the skin do not appear until the drug has been taken for some time, and personal idiosyncrasy does not seem to play so prominent a part in their causation as in that of the other varieties of medicinal eruptions, there not being manifest the same general condition of vascular irritability which is often connected with the latter. The production of the pustular dermatitis caused by iodine and bromine seems rather to be a question of the amount of the drug received into the system compared with the individual's capacity for its elimination by the proper channels; an interesting fact in this connection being the observation that in cases of Bright's disease, where the eliminating powers of the kidneys are crippled, this form of eruption takes place sooner and after smaller doses of the drug than usual.

As to the other varieties of medicinal eruptions, although they differ widely from each other in appearance, many of them are due to what looks like disturbance of the vaso-motor system, and belong to the so-called angio-neurotic lesions of the skin, the type of which is furnished by the wheal of urticaria; and both Pellizzari and Erb call particular attention to the general and increased irritability of the cutaneous vascular system which is present in these cases, a condition of things revealed by the ready formation of the so-called "*taches cérébrales*," first pointed out by Trousseau in connection with meningitis. Pathologically speaking, angio-neurotic lesions of the skin consist in various and varying degrees of dilatation of its capillaries, attended with more or less exudation of serum and wandering cells, separately or in combination, and such processes manifest themselves clinically by erythema of various types and urticarial eruptions. With regard to the bullous eruptions due to iodide of potassium, it may be stated that an angio-neurotic lesion of the skin, such as erythema or urticaria, may, by sudden and excessive exudation of serum, which causes the elevation of the epidermis *en masse*, develop into a bullous eruption, and it is a question as to how many of these pemphigoid lesions are of this nature. For the production of the hæmorrhages into the cutaneous tissues which take place in the purpuric eruptions, there is apparently necessary some change in the capillary walls themselves, for the red blood globule does not possess the power of amoeboid movement which enables the white blood-cell to migrate through the protoplasm of which the walls of the capillaries are composed. This process is generally independent of any angio-neurotic manifestations, although it may be combined with them, and thus give rise to a hæmorrhagic variety of such lesions. In what manner the presence of a drug, or some modification of the same, in the system causes such pathological changes in the skin: whether by disturbance of the central or peripheral nervous system, by irritation of the capillaries themselves, or by a combination of the two processes is a matter of speculation which is premature in proportion to the extent of our ignorance; but the truistic assertion may be made, that the entrance in some way into the circulatory system of the drug which causes them is requisite for the production of these eruptions. In any individual instance, the factor which seems to determine the morphology of the eruption is personal idiosyncrasy, or what Virchow has called the "*mystery of individuality*," the same drug generally causing the same form of eruption in the same individual, and it is an interesting fact that such idiosyncrasy may be hereditary.

The entrance into the circulation of vaccine matter and so-called septic material is also competent to excite pathological changes in the skin. In vaccination,

besides the more common and localized eruptions of erythema, eczema, and erysipelas, which start from the point of inoculation and spread by continuity, there sometimes occur exanthemata, which, appearing after a certain period of incubation, upon regions of the body distant from the point of inoculation, often resemble in appearance angio-neurotic eruptions, and are apparently due to entrance into the circulation of vaccine matter, or possibly, in some cases, as Behrend supposes, of the products of suppuration which has taken place at the point of inoculation. During the course of diphtheria and other septic processes, and notably puerperal fever, there not unfrequently occur eruptions of the angio-neurotic type, being made up of erythematous and urticarial lesions, and probably the so-called puerperal scarlet fever and the "scarlet fever" after operations are of a septic nature, and not genuine scarlatina. Bullous, and very commonly purpuric, lesions may also ensue in consequence of septic infection, and several observers have expressed the opinion that all cutaneous lesions, occurring as a result of such infection, are metastatic in character; and although this may not be true of all, it is not unlikely that the petechial lesions are of this nature, namely, hæmorrhagic infarcts of the skin caused by plugging of its capillary blood-vessels by emboli composed of micro-organisms, more especially as some recent microscopic observations, by Watson Cheyne, of the lesions occurring in purpura hæmorrhagica seem to confirm this idea.

In the cases already considered, the foreign material, or *materies morbi*, which excites cutaneous manifestations of its presence in the system, is introduced into the organism from the outside, and this may also be said of the acute and contagious exanthemata, of typhus and typhoid fever, of glanders, of syphilis, of the oriental pest, and of infectious maladies, where cutaneous eruptions are exceptional and not characteristic of the disease, such as cholera, relapsing fever, and acute miliary tuberculosis; but instances are not wanting in which similar appearances may be caused by the formation in the organism itself of material which by its presence in the blood is competent to give rise to changes in the skin, and examples of this are furnished by scurvy, uræmic poisoning, and diabetes.

Chemical examination of scorbutic blood shows, besides other changes in its composition, increase in the amounts of water, fibrin, and albumin, and decrease in the quantity of its globular elements, and these changes, which are apparently caused by exposure to hardship combined with deprivation of certain articles of diet, notably fresh vegetables, are attended by the development of purpuric lesions in the skin and hæmorrhages into other tissues of the body. There is no reason for supposing scurvy to be an infectious malady, and the suggestion that the purpuric lesions of the disease may be due to the influence of the same micro-organisms which are ordinarily harmless denizens of the mouth and other cavities of the body, but which in these cases are furnished with unusual opportunities for growth and development on account of the altered composition of the blood, is a curious instance of bacterio-mania.

In chronic diminution or complete arrest of the renal functions, the consequent retention in the blood of waste products which should be eliminated by the kidneys usually manifests itself by headache, symptoms of gastric disturbance, and in severe cases by coma, but occasionally there are likewise produced cutaneous symptoms, consisting of a papular form of erythema, attended with exudation and followed by desquamation, which has been described under the name of erythema uræmicum. This form of eruption usually makes its first appearance upon the extremities, notably upon the extensor surfaces, and subsequently spreads to other parts of the body. Confluence of the original lesions sometimes

causes the eruption to assume a likeness to that of scarlet fever, and in one case of unusual severity bullæ and purpuric lesions were formed in the skin, and hæmorrhages took place into the mucous membrane of the mouth.

The cutaneous manifestations which occur during the course of diabetes, apparently in consequence of the overproduction of sugar in the system, have been made the subject of a special article by Kaposi, and may be of the angio-neurotic type represented by roseola, erythema, and chronic urticarial lesions, or of a more frankly inflammatory nature, consisting of furunculosis, carbuncular lesions, and even gangrenous dermatitis. The presence of sugar has been demonstrated in these inflammatory lesions, which call to mind the similar cutaneous changes caused by iodine and bromine.

The eruptions which have thus far been mentioned are, properly speaking, not diseases of the skin, but changes *in* the skin, which are symptomatic of the presence in the circulation of some material which is foreign to the organism, and which either enters into it from without or is the result of perverted and incomplete performance of its physiological functions. In a crude way they may be arranged in three groups, namely: those of an angio-neurotic nature, represented by the various forms of erythema and urticaria; those of a reactive inflammatory and suppurative type, consisting in acneform, furuncular, and carbuncular lesions; and those of a hæmorrhagic variety, manifested by purpuric eruptions, and it is worthy of notice that eczema, which is so common a disease of the skin, is so rarely met with in this connection.

The pathological changes in the skin, which are regarded as cutaneous diseases properly so called, are not unfrequently purely symptomatic in their nature, and a rational method of treatment does not lose sight of this fact, although the exact indications to be met are often obscure or entirely unknown.

The acute outburst of urticaria, sometimes accompanied by vomiting and febrile symptoms, which occurs after the use of certain articles of food in susceptible individuals, has its exact counterpart in the similar eruption following the use of various drugs, and many strange examples of such personal and gastronomic idiosyncrasy are recorded. The typical and self-limited course of erythema multiforme, erythema nodosum, and certain varieties of purpura; the prevalence of these diseases during the spring and autumn; the individual susceptibility which renders the patient liable to renewed attacks with the return of these seasons; the general feeling of languor and debility and arthritic pains which are often evident, and the occasional development of cardiac murmurs during the course of these maladies, all go to show that their cutaneous lesions are merely symptomatic of some general and possibly infectious influence, the exact nature of which is entirely hypothetical.

The chronic varieties of erythema and urticaria, on the other hand, which by recurring attacks form such an unpleasant feature in the existence of the sufferers therefrom, are symptomatic of some disturbance of the various physiological functions of the body, and external applications have upon them but a temporary and palliative effect. They may often be associated with manifest symptoms of dyspepsia, with costiveness, and with improper modes of living, in which case the appropriate and generally effective remedy is to set right whatever is wrong, so far as lies in our power. The evil effects of the incomplete performance of the digestive and excretory functions are not limited to symptoms referred to various parts of the alimentary canal, and may even make themselves felt without any marked manifestations of the latter, and the lassitude,

drowsiness, and general debility so often met with in these cases are probably but milder manifestations of changes in the blood which may even result in symptoms of coma, such as have recently been described as following, and probably caused by, dyspepsia. A sedentary life in a vitiated atmosphere, and improper food, are to many the ordinary conditions of existence, and plenty of fresh air, physical exercise, and regulation of the habits and diet are often more called for than drugs; but occasionally instances are met with where there is no obvious derangement of any but the cutaneous system, and where the functions of digestion and elimination are performed with regularity and apparent completeness, and consequently our therapeutic efforts must sometimes be made at random. But the facts which come within the narrow limits of personal experience, that such cases are sometimes much relieved or even cured by the administration of salicylate of soda, atropia, or by a thorough-going course of purgative waters, are suggestive of future possibilities in the way of therapeutics, when our knowledge of the action of drugs and the indications for their employment is more exact than it is at present. There is no doubt also that eczema and other cutaneous disorders, which are not so purely symptomatic in their nature as those already mentioned, may be aggravated and kept up by similar conditions of the system, and a strict attention to the functional integrity and vigor of the body, in addition to local treatment, is often necessary to secure a successful result. Disturbance of the nervous system and exudative or inflammatory tissue changes are but the machinery of pathology, which is set in motion by what in the broadest sense of the word may be called irritation, and doubtless one form of such irritation is change in the composition of the blood by quantitative or qualitative modification of its various constituents, or by the introduction of foreign material, and the patient who makes the traditional demand for its purification may, in many cases, be nearer the source of his malady than the physician who is busy with the symptoms. However clumsy and ineffectual our therapeutic efforts may be, they should not be employed without a clear recognition of the close relations existing in matters of pathology between the body and its cutaneous envelope, which renders dermatology, of all the special departments of medicine, the least independent of general pathological states of the system.—GEO. H. TILDEN, *Bost. Med. and Surg. Jour.*, July 23, 1885.

Received.

Treatment of Eczema, by HENRY J. REYNOLDS, M.D. (Reprint).

Mittelbare Uebertragung des Ulcus Molle, von DR. EDMUND LESSER (Reprint).

Ueber Lepra in Norwegen und über einen Fall von einheimischer Nervenlepra von PROF. DR. EDUARD LUNG (Reprint).

La Lèpre et son Traitement, par le DR. E. VIDAL (Reprint).

Des Nodosités non erythémateuses chez les Arthritiques, par le DR. L. BROCCQ (Reprint).

Etude sur le Mycosis Fongofide, par E. VIDAL et L. BROCCQ (Reprint).

Die Elephantiasis Arabum, von DR. H. VON HEBRA (Reprint).

Item.

PATENT HAIR RESTORATIVE.—Mr. Rudolph Damann has recently procured a U. S. patent for a "composition of matter to be used as a hair restorative, consisting of lime, plumbago, borax, beeswax, tallow, salt, lac sulphur, and coal oil."

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Original Communications.

ANGIOMA PIGMENTOSUM ET ATROPHICUM, TAYLOR.
MELANOSIS LENTICULARIS PROGRESSIVA, PICK.
LIODERMIA CUM MELANOSI ET TELANGIECTASIA, NEISSER.
XERODERMA PIGMENTOSUM, KAPOSI.
DERMATOSIS KAPOSI, VIDAL.¹

BY

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IT is my purpose to present a brief account of two cases of this disease which have lately come under my observation. This peculiar affection, characterized by so many and so striking pathological processes, has been so ably studied of late by such competent observers as Neisser, Vidal, and Pick, and its appearances so well pictured by the latter two, that little remains for me but to add this report of additional cases to the lists published by them.

The cases occur in a family of Russian Polish Jews. The parents have lived in Russia, England, New York, and Boston. The mother is a healthy-looking woman, stout, of fair complexion, dark-brown hair and eyes. She says that she has always been well. The father, by the wife's report, is a blond with light hair and eyes. No such disease has occurred previously in either family to their knowledge.

The boy Louis came to the Massachusetts General Hospital Out-patient Department, July 27, 1885. He was asked if there were other cases in the family, and on the statement that a little brother had the

¹ Read at meeting of Amer. Derm. Association, Aug. 26, 1885.

same disease, he was told to come on the following day with him and the mother. Drs. Greenough and Tilden were present by invitation. The mother gives an account of her children as follows:

1st child, girl. Died at age of 12 of fever. Skin unchanged.

2d child, boy, æt. 17. Case 1.

3d child, girl, æt. 15. Skin unchanged, eyes and hair black, has few freckles.

4th child, boy, æt. 11. Skin unchanged, eyes blue, hair brown.

5th child, boy, æt. 5. Skin unchanged, eyes and hair black, skin deep olive.

6th child, boy, æt. 3. Case 2.

7th child, girl, æt. 1½. Skin unchanged, eyes blue, hair brown.

This condition of the family was confirmed by a subsequent inspection.

CASE I.—Louis Berrick, æt. 17. The mother first noticed a change in the skin before the child was two years old, and while they were living in Poland. A few freckles, as they were then supposed to be, appeared upon the face and later upon the hands, which increased in numbers up to the age of six, when the family emigrated to England, leaving Louis behind. He was not seen by the mother again until two years ago, an interval of nine years, when he joined the family in Boston. At that time the melanoderma was nearly as marked as at present, but the leucoderma was just beginning to develop, and has been steadily increasing in area since then. When the telangiectasic condition appeared is not known, but the mother thinks that it was as noticeable when he rejoined the family as now.

The patient as an infant was well developed and always healthy. As a boy he continued to have good health, but has grown slowly, and is now not larger than a boy of twelve years. The muscular tissue is firm, and the genitals, although small, are well developed. The hair-growth about them is scanty, but upon the scalp it is very thick and of an intense blackness. The eyes are also very black. It is impossible to determine with certainty the natural color of the skin, so universally has it become affected by the disease.

Present appearances: Melanosis.—The forehead, cheeks, lower face, and neck are of a very dark brown, apparently uniform in tint, but on close inspection small darker spots are seen to cover the parts very thickly, resembling strongly the skin of a badly freckled dark mulatto. The tint of the whole trunk is as dark as that of a dark Spaniard, and superimposed there is a dense spattering of a still darker hue, least noticeable over the central abdominal region, but nowhere absent. The scrotum is very black, and the penis and glans present sparse, but very dark spots. The arms, particularly the extensor surfaces, are very thickly spattered, and the hands are very deeply colored and bespotted, some of

the blotches here being of an intense blackness. The nails present a natural appearance, and the palms are unspotted. The thighs, like the trunk, are of a lighter tint and more sparsely freckled, but one of them presents upon its inner surface an almond-shaped blotch of the deepest black, slightly elevated, smooth, and sparingly covered with a hair-growth of considerable length. The lower legs are very dark and thickly occupied by blotches of larger size and blacker color than elsewhere. The mucous membrane within the mouth and larynx (carefully examined by Dr. Langmaid) is free from melanosis.

Atrophic or leucodermic condition.—On the right side of the face, occupying at least one-half of its surface, is a sharply defined area entirely without pigment. Similar areas are seen upon the other cheek, the forehead, and about the mouth. The surface of these parts is smooth, and has a stretched, glistening appearance. In places the skin thus affected has a pinkish hue, and the deep veins are readily seen within it. The integument here is apparently thinned, and resembles superficial scar tissue. The ears are very thin, but show no loss of cutaneous pigment. They resemble tanned sheepskin. No leucodermic patches, but a few minute white dots are seen upon other parts of the body. The striking contrast between the white areas upon the face and the intense blackness from which it is so abruptly separated, gives it an indescribable appearance. The sensibility of the atrophic districts, tested by Dr. James J. Putnam, is decidedly impaired. Touching them with the end of a string was unrecognized by the patient, although the prick of a pin was appreciated. The sweat glands are less active in the leucodermic areas.

Telangiectasis.—Over the central parts of the face there are numerous bright-red, slightly elevated spots, varying in size from a large pin's head to a small pea. They are most noticeable and abundant in the leucodermic patches, on the lips, and about the edges of the eyelids. Within the lids near the edge are two angiomatous new-growths, more elevated than those of the integument. A few of the red spots are seen upon the ears and the backs of the hands, but they are not very conspicuous. Several greatly enlarged vascular twigs are also noticeable upon the face, especially upon the *alæ* of the nose. On very close inspection, a few minute red points may be discovered over the general surface.

The vascular hypertrophy cannot be represented in the accompanying woodcut.

CASE II.—Iza, a well-grown boy, 3 years old. He was born in New York. When he was 18 months old, his mother for the first time noticed a few light-colored freckles upon the face, which largely disappeared during the following winter. Since then the present appearances have been gradually developing. The hair is rather dark brown, the eyes are black. The tint of the skin is brunette. The mother says

that the eyes of both these children are very weak, during the summer especially. Those of Iza appear very sensitive when directed towards the window. The mental condition of both seems to be normal. The face is universally covered with small, deep-brown freckle-like spots on a general brownish ground. A few of them are deep black. The spots are so small and thickly distributed that at a little distance the face looks as if deeply and uniformly tanned. In some parts they are slightly thickened and rough to the touch, as patches of *keratosis senilis*. The backs of the hands and wrists are uniformly covered with innumerable, very small, faintly brown spots. Elsewhere the skin is of its natural color. There are no leucodermic patches and no telangiectasis.

Of the correctness of the diagnosis in these cases there could be no question at the first glance to one familiar with the descriptions of the affection. Three of the distinct pathological processes which characterize it are present in the oldest patient in a marked degree: the melanosis, the vascular new-growths, and the superficial atrophy of the skin. There is lacking only the almost constant, final transformation into carcinoma. In the second case, seen in the near beginning of the disease, we have only one condition present, namely, the pigmentation. From a careful study of this in its inception, and of the parts last affected in Case I., I conclude that the disease begins, or at least has begun in them, with an excessive formation of pigment in the shape of minute points; that these points enlarge and take forms in no way to be distinguished individually from ordinary freckles. They appear to be evanescent at this stage, like the latter, and affect, like them, parts most exposed to light; that is to say, the melanoderma begins to manifest itself upon parts of the skin naturally prone to just such irregular pigmentation in childhood. It occurs, too, with just the same absence of all unusual subjective or objective precedent or apparently causative phenomena, as in *lentigo*. In these cases, there had been no exceptional exposure to sun or visible hyperæmia before the beginning of the melanosis. Gradually the lenticular spots multiply until large surfaces are entirely occupied by them, but never so as to form uniform areas of considerable extent, as in other forms of melanoderma, the skin always appearing spotted or blotched with well-marked lentiginous shapes. They advance slowly and regularly, too, from the face, hands, and feet towards the central parts of the general surface, thus allowing an easy study of the course of development of this feature of the disease. It is probable that several years, certainly two, may pass, and no other manifestation of the disease present itself. Case II. shows that within two years from its start, the pigment cells may increase so much faster than they are removed by the natural process of desquamation that they may heap themselves up and form marked elevations, and that a verrucous,

papillary hypertrophy may develop beneath such pigmentary keratoses within the same period. In Case I., on the other hand, we have the disease in progress for fifteen years without any such accumulation of pigment cells or papillary hypertrophy; but only a single, small, flat, somewhat elevated *nævus pigmentosus et pilosus* of uncertain duration as an indication of advanced pigment change.

How early the telangiectasis appeared in Case I. cannot be ascertained. It is now most apparent in the part longest the seat of the melanoderma, viz., the face. It is nowhere present upon parts last affected, nor has it yet developed in Case II. after eighteen months of melanosis. These observations led me to the belief that it is a secondary condition, certainly not necessarily the initial process, nor even coincident in some cases. It is by far most developed in Case I. in the areas of atrophied skin, as if developed there anew, as in some cicatrices, or, at least, as if left behind unaffected by the atrophic process. Telangiectasis is not a common sequence of melanoderma in any of the many other forms of the latter, nor are the ordinary, superficial, vascular new-growths of the skin, the enlarged vascular twigs, the "spider cancers" ever followed by pigmentation. The two processes seem, therefore, to have no real pathological association. I exclude from this class of phenomena, of course, the melanoderma which may follow dif-fused hyperæmia of all grades.

In this connection, however, I must appropriately refer to a case which came under my observation two years ago for a very brief period. It was a woman, 28 years old, who, five years previously, during pregnancy, noticed the development upon her face of numerous telangiectases, or red spots, as she called them, which disappeared largely after confinement. The following year she again became pregnant, and the "spots" re-appeared and remained. She believed that they had been increasing in number since then, but that some of them had vanished and had left behind them brown spots; at all events, brown spots had been appearing in a very conspicuous manner. The forehead and upper face, especially in the vicinity of the eyes, were very thickly occupied by linear and lentiginous-shaped, discrete telangiectases of a very brilliant hue. Interspersed with them were numerous freckle-like pigment spots of all shades, varying from a light buff almost to black. They were also thinly scattered over the cheeks and upon the sides of the neck. The patient had never before exhibited freckles. I could see no evidence of a transformation of a telangiectasic spot into melanosis, or *vice versa*. They appeared entirely independent of each other in position and development. There were no atrophic areas. The appearances as a whole were very striking, and I was in doubt whether to regard them as an exceptional instance of the disease we are considering or not.

Neither in these cases do I observe anything which shows the transformation of an individual pigment spot into a telangiectasis, or *vice versa*, nor is there any necessity of such a presupposition. Both processes are very common ones in themselves, and, as already stated, have ordinarily no such relationship or even association. The new-growth of blood-vessels certainly underlies that of pigment, and in my cases is certainly subsequent to it. The two processes may be regarded as no more closely allied than associated or coincidental features of a strongly marked pathological condition of the skin.

Nor can the date of the beginning of the atrophy in Case I. be ascertained. It occupies considerable areas, and has without doubt been in progress for several years. The atrophy embraces a large part of the thickness of the integument, as shown by the thinning of the *alæ* of the nose and of the ears—parts which permit the loss of tissue to be readily estimated. I should judge that the papillary layer with the underlying superior plexus of vessels at least had wholly disappeared, and that the glandular structures had also mostly perished. The follicular openings were no longer apparent. The relation of this atrophy to the two processes above described is to me incomprehensible. We know that some forms of abnormal pigmentation of the skin are capable of self-involution, that others involve the tissue in which they are deposited in exceptionally rapid destructive processes, that others have an intimate association with carcinomatous disease, and that in some varieties or instances of morphea we do have the close combination of melanoderma, vascular hypertrophy, and atrophy of the skin also, but the observation of these facts affords no satisfactory explanation of their occurrence. The *atrophia cutis* must be ranked as step three in the history of the disease.

That two more processes are likely to be developed in the future of Case I. is more than probable, viz., hypertrophy of the epithelial and papillary layers, and later a transformation of the same into epithelioma. This has been the sequence of tissue-change in so large a proportion of the thirty-three authentic cases thus far tabulated by nine observers, and embracing only individuals of a dozen families, more or less, that this grave prognosis can hardly be avoided in so well-marked an example of the affection.

I have but a word to add concerning the title of the disease. From my limited opportunity of study, I consider that recommended by Dr. Taylor, and adopted by our Association, *angioma pigmentosum et atrophicum*, as ill chosen in some respects, for I cannot regard the *angioma* as first in importance of pathological significance, or deserving priority as the initial lesion. The term *melanosis* seems to me in these respects to deserve precedence. The additional terms *lenticularis* and *progressiva*

of Pick are significant, but for descriptive titles not sufficiently comprehensive. We should go further, if we would thus completely define it, and add *telangiectodes* and *atrophica*. It is to be regretted that some single name, arbitrarily selected, if need be, should not be adopted for a disease so remarkable in its complex and exceptional diversity of tissue-change and protracted progression.

ON THE RELATIONS OF LUPUS VULGARIS TO TUBERCULOSIS.

BY

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(Continued from page 335.)

IT is scarcely necessary in this connection to enlarge upon the admitted fact, that up to the present date the investigation of the relations between lupus vulgaris on the one hand, and the several conditions described as tuberculosis and struma on the other, has had the result of establishing two different schools of belief.

The opinions of the first to be described are represented in the earlier writings of Fuchs and Plumbe, by a large number of French authors, including the distinguished names of Bazin, Devergie, Hardy, and more recently that of Besnier; by the late Sir Erasmus Wilson and a number of other prominent writers of Great Britain; and in this country, in our own day, by several of our colleagues. The views they have entertained differ in minor particulars, but in the main all have been agreed as to the relation between the diseases in question. They have held to the doctrine, that before there could be a lupus or a scrofuloderm there must have been a systemic condition, which etiologically explained the local disorder. This systemic condition, illy defined, it must be said, by the very ablest exponents of this theory, was held to be a species of physical vice, inherited or acquired, more frequently the former, inducing in its subjects a remarkable deviation from the normal processes of nutrition, development, and reproduction. They thus set aside, as it were, in one great pathological family a large number of the human race, who were doomed, if they became the victims of accident or disease, to certain consequences from which all their fellows were exempt. No need to-day, surely, to go over the ground which has been slowly rescued from this enormous domain. Dismissing all the loose statements and all the erroneous diagnoses which have been made under cover of these teachings, we now know that much of this field has been properly assigned to

sypilis, and another part to disorders which cannot to day be regarded as having a constitutional origin. Thus restricted, the ground has been held, and often well held as regards the strict relation between lupus vulgaris and what is termed scrofula. While one party in this school has contended that lupus, struma, and tuberculosis were different manifestations of a single disorder; and another, that they were merely allied and related members of a single family; it cannot be denied that all were in practical agreement as to the constitutional origin of the several disorders thus claimed to be identical or related. Before there could be a lupus, there must be an antecedent scrofulous cachexia, diathesis, vice, or predisposition. No one of these advocates, as far as I can discover, has ever printed a line, or uttered a suggestion, upon which could be based an argument in favor of an infection of the system beginning as a strictly local disorder, a primary scrofulosis so to speak, entirely unconnected with a systemic state. A few quotations may serve to illustrate this point:

Devergie,¹ for example, wrote: "If an eczema manifested in youth possesses a special physiognomy, it is essentially scrofulous, and can only be cured by modifying the constitution."

Hardy,² also, states that the "cutaneous manifestations of a general condition are called scrofulides."

Besnier and Doyon³ express themselves as follows: "What are chlorosis, anæmia, dysmenorrhœa, seborrhœa, sterility, chronic catarrh of the pulmonary apices, and incipient tuberculoses, if not diverse manifestations of the same constitutional cause?"

Thus also the late Sir Erasmus Wilson⁴ wrote: "Scrofula or struma is a state of the animal constitution."

And lastly, Dr. Piffard⁵ describes the "scrofulides," as "affections which are the outward manifestations of a general constitutional condition or diathesis, which diathesis may be hereditary or acquired, and last indefinitely or for life."

The second and opposing school of belief in this discussion has denied positively a relationship between lupus vulgaris and a tuberculo-strumous diathesis. This denial has been for the most part based upon the sufficient clinical facts to which attention has been called above. Their views were best expressed by Hebra, and have been stoutly maintained by his followers since his teachings first received support in the scientific world.

¹ "Trait. prat. des Mal. de la Peau," Paris, 1837, p. 630.

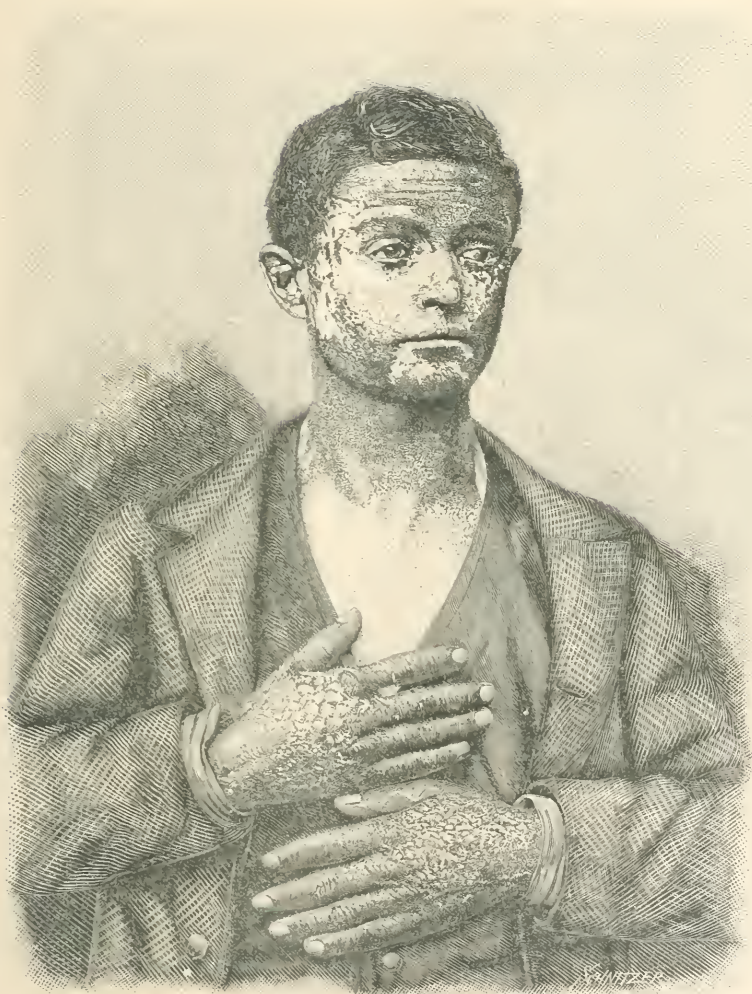
² "Maladies de la Peau," Paris, 1866, p. 18.

³ Notes to their French translation of Kaposi's "Treatise on Diseases of the Skin," Paris, 1881, p. 247.

⁴ "Lectures on Dermatology," London, 1875, p. 31.

⁵ "Diseases of the Skin," London and New York, 1876, p. 52.

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Dr. White's Case of Xeroderma Pigmentosum.

A careful study of the written opinions of most of the Vienna school of dermatologists discloses the important fact that, while thus denying the etiological relation between the diseases under consideration, they put forward no theory of their own as a substitute for the other. They did not contend that they or others had solved the problem. In this confessed ignorance they contented themselves simply with further study of the disease. They established firmly the clinical facts set forth in the record of the cases here collated. These facts are as old as the study of the disease itself. It is these that, even in the present state of our knowledge of the subject, have constrained Doyon to call lupus a "form" of tuberculosis merely; Walter Smith, to name it a "variety" of the same disorder; Neisser, to use the expression, "a partial manifestation" of tuberculosis; and Baumgarten, Schüller, Friedlander, and others, to advance arguments by which these facts might be either offset or explained. These same facts show incontrovertibly that the subject of lupus vulgaris may be born of sound parents, and have a family record in which for generations there may be no trace of lupus, struma, or tuberculosis. He or she also may reach maturity and never suffer from any disease of consequence save always the lupus. He or she may marry, procreate healthy children who may accomplish the same physical destiny without exhibiting signs of an inherited disorder. Finally, these subjects of lupus vulgaris may die at an advanced age of some accident or intercurrent disease. With these facts in mind, we can with ease explain such a case as that lately reported by Dontrelepont, for example,¹ in which the subject of lupus vulgaris developed also a tubercular meningitis. Neither can it be difficult to account for the experience of Besnier,² as lately published by him, eight of whose thirty-eight patients affected with lupus, had also tuberculosis. The mere circumstance that it has become necessary to publish such reports is the strongest commentary upon their rarity. But these figures, however correctly they may represent the ratio of concurrence of lupus and tuberculosis in France, can in no sense be accepted as expressing the percentage of such coincidences in this country. The strength of the clinical argument against the views entertained by the French School of authors is as unshaken to-day as when Hebra's earliest doctrines on this subject were first given to the scientific world. They will so remain while the mass of mankind continues to live with its present social environment. Whatever exact relations may hereafter be established between lupus vulgaris and tuberculosis, the majority of patients suffering from the one disease will certainly never exhibit the symptoms of the other.

But we are suddenly and recently confronted with a revelation for

¹ Deutsch. Med. Wochen., No. 7, 1885.

² Annales de Derm. et de Syph.

which we are indebted to the labors of the pathologists, which throws a flood of light upon this and its allied questions. Koch was first to recognize the bacillus tuberculosis in flaps of lupous tissue, and subsequently cultivated these same bacilli outside of the living body, producing lastly tuberculosis in the tissues of some of the lower animals by injecting them with these culture-fluids. He has been followed by Doutrelepon, Weichselbaum, Meisels, Lustig, and others, who claim to have repeated his experiments and thus verified his conclusions. A large part of the scientific world to-day holds that the correct explanation of the question at issue has been reached. To my mind it furnishes the only adequate solution of the problem which is possible, and demonstrates the fallacy of the position occupied heretofore by the adherents of the school of observers first described above. Curiously enough, one of the most earnest champions of the old theory of the constitutional origin of tuberculosis and lupus is to-day calling attention to the alleged confirmation of this theory by the later pathologists.

But the moment that we examine the bearings of these newly-demonstrated facts, we find that they are far from lending support to such doctrines. They place before us the disease whose etiology has been long unknown, as a strictly infectious and parasitic disorder. Given proper conditions for infection by transference of the parasite, and we find persons of perfectly sound health exhibiting the signs of the disease. According to this view, lupus vulgaris never results from such a systemic cachexia, vice, tendency, or diathesis, as has been believed and taught, but is always at first, and possibly even throughout its evolution, a strictly local disorder, unconnected with any involvement of the system. This limitation to the skin and to certain parts or regions of the skin is due to the unfavorable local conditions here supplied for the development and multiplication of the infectious germs. This development, however slowly proceeding, and this multiplication, however unfavorably conducted in the skin, is characterized by a rapid progress when occurring in the warmer and more delicate endothelium of the pulmonary alveoli. The primary point of points of infection by the lungs are the more frequent sites of this accident, by as much as they are more favorably situated for the culture of the parasite. It follows necessarily, and I think it important to call attention to this point, that just as we may find several simultaneously-infected points upon the skin, as when lupus vulgaris exists both on the face and on one or more of the extremities, so we may have exceptional and rare cases in which the skin may be infected with lupus and the lungs later with a pulmonary tuberculosis. We must insist upon this possibility with all of the bearings in every anomalous or exceptional case. If the lupus of the skin be due to an accidental infection at one or more points, and pulmonary tuberculosis be merely another

accidental infection of another organ of the body, before it can be held that the one accident is in any way related to the other, the possibility of simultaneous occurrence of such accidents must be set aside. Or, to state the question somewhat differently, it is more reasonable to assume that the bacilli claimed to produce lupus gained access to the lungs precisely as they gained access to the skin, than to assume, first, an access to the skin, second, a constitutional involvement and a resulting general cachexia; and, third, an infection of the lung as a result of the latter. Already we can discover dawnings of this truth in the claim set forward that true tuberculosis of the skin is always the result of a tuberculosis of the system at large; while lupus as a primary lesion differs in a marked degree from this species of tertiary lesion of bacillus-possession.

Let us look for a moment somewhat in detail as to the mode by which this parasitic etiology of lupus vulgaris explains many of its clinical features.

First, the patient affected with the disease may be perfectly sound, with an unimpeachable family record, and free from any demonstrable constitutional vice. The disease, from the first day to the last, may be purely and solely a skin disease, the parasite in this case attacking the skin only, and leaving the other organs sound.

Second, lupus vulgaris, certainly in its inception, is a disease of childhood and not of infancy. It is rarely apparent before the third year of life.

At this period of existence, the child has really emerged from the infantile state and has usually completed its first dentition. As a rule, it is no longer subjected to the daily complete ablution of the body given by the mother to a young infant, and in its waking hours is no longer the object of an incessant attention. Often, indeed, a subsequent pregnancy or the birth of a younger child has operated to transfer a large part of the care it originally received, to the person of a younger brother or sister. In this connection it would be highly interesting to discover how many patients affected with lupus vulgaris were eldest children.

The child thus situated has reached that period of life when education has not had opportunity of establishing the habits of cleanliness, and is quite unprovided with an instinct enjoyed by the young of many of the lower animals, which at intervals assiduously cleanse the entire surface of the body by the aid of claws, talons, beak, tongue, or teeth. By nature many of its habits are filthy; and when it is neglected, it often surpasses in uncleanness many of the lower animals. Its hands are brought into contact with the accessible parts of the body with fully as much freedom when soiled as when unsoiled, in the act of picking, scratching, and rubbing. Its amusements and close personal contacts are chiefly

with children of a like age, as unprotected as itself from the accidents of infection. Much of its time is spent on the floor or upon the ground, even when in active movement. In this way, not only the traumatisms that are self-produced, but those inflicted by accidents related to its feeble steps, uncertain use of muscles, and sudden impulses, are so many sources of danger.

Third, the several sites of lupus vulgaris, as thus developed in childhood, are precisely those to which attention would be directed by the play of the hands and by the commonest contacts with foreign bodies. Thus the relatively short upper extremities of the child reach without difficulty to the portions of the face below the line of the brows, especially to the nose, the cheeks, the lips, the ears, and the chin, most frequent sites of lupus vulgaris; while the rarer of the cephalic sites, the brows, the scalp, and the nucha, are incontestably less accessible.

Again, at the age under consideration, it is common, at all times in warm latitudes, and during the summer in colder climates, to leave the upper and lower extremities exposed, the feet being bare, and often the legs below the knees, while the arms, from the elbows down, including the hands, are similarly uncovered. It is scarcely necessary to say that these are the situations where lupus vulgaris of the extremities, the next site of predilection of the disease after the face, is usually developed. Recognizing the fact that females are in slight preponderance as regards the frequency of infection by lupus, it would be interesting to discover whether lupus vulgaris of the extremities is not more common in the male sex, boys being more often than girls permitted to go with the feet and legs uncovered. The only case of lupus vulgaris of the extremities collated in the preceding pages occurred in a male subject. We note here, too, that as in the eczemas of several of the trades, the tender and more delicate surface of the back of the hand and foot is more commonly the seat of the disease than the thicker palmar and plantar tissues, which, if involved, are commonly reached by extension of a serpiginous lupous infiltration from the other parts named.

Next in order of frequency come the buttocks. These are not only accessible to the hands of the child, but are often as much exposed as the hands and the feet to accidental contacts when the child is seated on the ground or upon the floor, often, indeed, being at such times quite uncovered by the dress.

Again, at the period of life reached by the child whose habits we are considering, the sexual instinct is dormant, and there is almost no solicitation to carry the hands to the genital region of the body. The character also of the dress usually worn at this age is such as to generally require the aid of a nurse or attendant to completely expose the parts. We are thus not surprised to learn that lupus vulgaris of the genital region is

of exceedingly rare occurrence, and when so situated is usually reached by extension from the thigh on the one side or on the other, or from the belly above.

Fourth, lupus vulgaris is not recognized as an inherited disease. The new doctrines held on the subject of pulmonary tuberculosis, since the later investigations of its etiology, point decidedly to new infection of the children of phthisical parents rather than to an inheritance of a parasitically begotten disease. The evidence employed to induce belief in the possibility of inheriting lupus vulgaris would not be regarded as admissible in any court of evidence governed by the common law.

Fifth and lastly, the obvious tendency of lupus vulgaris to a strictly cutaneous limitation is not without analogy in other disorders of the skin produced by diseases that may involve also other organs. Syphilis furnishes such an analogy, and that whether we accept or not the recent claims set forth by Lustgarten and others, that syphilis is a disease also produced by a species of bacillus. The more dangerous of the syphilitic visceral troubles rarely occur in those who have suffered from the severest skin lesions. By "severe skin lesions," I do not mean the formidable ulcers only that form, usually few in number, after the degeneration of gummata, but those rare cases most like lupus-forms, where the entire surface of the body has been for years the seat of an extensive serpiginous ulceration, seaming the integument with scars from the head to the feet. These are rare cases, chiefly probably because the disorder is so amenable to treatment that it is rarely permitted to have such sway, but such cases are occasionally seen by the expert where the disorder has been either unrecognized or untreated. In every one of the cases of very extensive involvement of the skin with syphilitic ulceration that have come under my observation, the bones and viscera have been spared. Yet I lately saw the liver, spleen, and brain studded with gummata in the case of a subject dead of syphilis after six months of infection, with the most trifling of cutaneous accidents. Indeed, it is well worth inquiring whether the well-nigh abandoned syphilization processes did not accomplish much the same end by keeping the skin in a constant state of efflorescence, as far as was possible, by the aid of indefinitely multiplied traumatisms.

TREATMENT OF CICATRICES OF THE FACE.—In the treatment of cicatrices of the face, particularly of the lower jaw, all unsightly scars may be avoided by using a dressing of perchloride of iron, ʒi.; collodion, ʒij. Let the cicatrix be cut clear off and the dressing applied every day, and a barely perceptible line will be the result.—DR. GENESE *Med. Med. Journal*, Sept. 12, 1885.

DERMATOLOGICAL NOTES.

BY

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Inherited Keratosis of Palms and Soles.

IN the May number of this JOURNAL, Dr. G. H. Fox reported a case of the above disease. Mr. B. came to me for the relief of the same trouble. The condition of the palms and soles was such as to allow only of an insignificant amount of motion. This condition has existed since infancy. His brothers and sisters were all similarly afflicted. The disease in this case was inherited from the father, who, together with his brother, suffered also with keratosis of the palms and soles.

Electrolysis.

I would like to call attention to the destruction of chancres by electrolysis. This operation is original with me—at least I am not aware of any one having performed, reported, or suggested it. The results, in the cases on which I have operated by this method, have so far been very gratifying, and have led me to consider it preferable to excision. The electrolytic process has probably a destructive action on the virus beyond the seat of actual destructive tissue, whilst in excision a certain amount of tissue only is removed—without any influence beyond the line of incision—and which may or may not include the entire virulent mass, thus accounting for varying results. This operation by electrolysis was undertaken with the view of ascertaining whether or not the initial sclerosis be purely local, which I am inclined to believe, or merely a symptom of constitutional syphilis. I reserve a subsequent paper on this subject for the time when sufficient evidence will have been collected to justify its appearance.

Ethereal Solution of Caoutchouc.

Lately I have been using the above solution with satisfaction. The ether (I use Squibb's) is less irritating than the chloroform in the liq. gutta-percha and the caoutchouc preparation is also more elastic than collodion. Hence the caoutchouc-ether solution is preferable to either collodion or traumaticine in certain cases. A quantity of this solution, mixed with ointments and spread upon muslin, makes a very good adhesive dressing.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

157TH REGULAR MEETING, OCTOBER 27, 1885.

DR. W. T. ALEXANDER, *President, in the Chair.*

DR. FOX presented a

CASE OF LUPUS ERYTHEMATOSUS.

Eliza M., 51 years old. The present eruption made its appearance eighteen months ago on the head, and soon after on other parts of the body. Previous to that she was free from any skin lesion whatever. The patient now has red, scaly, and irregularly oval patches upon the chest and under both breasts; there are some large, scaly papules on both elbows. Upon the back, near the upper border of the left scapula, is a sharply circumscribed oval patch, with an irregularly raised surface. Behind the right ear is a small ulcer with raised edges. There are also scaly spots in the hair. The eruption has always been dry, forming scales, which are shed off. There is no itching.

In presenting the case, Dr. Fox said the diagnosis of lupus erythematosus, rodent ulcer, and psoriasis had been made by various physicians.

DR. BRONSON did not think the case was lupus erythematosus, but eczema; he had never seen the former disease present a moist surface. Some of the patches, especially the one behind the ear, he considered to be epithelioma.

DR. JACKSON believed that the lesion behind the ear was an epithelioma, that on the body lupus erythematosus.

DR. ROBINSON said that the eruption behind the ear was an epithelioma, and based his diagnosis on the waxy appearance of the lesion and its raised margin. He was not prepared to diagnose the eruption upon the body.

DR. ALEXANDER said that he had seen the case in Charity Hospital about a year ago. The patch on the upper part of the breast was then only about one-quarter of its present size, and was also much paler. It was diagnosed as psoriasis, and treated with chrysarobin. He afterward saw the case with Dr. Fox, and then there could have been three diagnoses made, viz., psoriasis, lupus erythematosus, and epithelioma. He would call the lesion behind the ear an epithelioma.

DR. FOX thought that the majority of members who would examine the patch on the breast by daylight would consider it a lupus erythematosus, and the condition existing behind the ear and on the back of the neck rodent ulcer or epithelioma.

DR. MORROW brought forward a

CASE FOR DIAGNOSIS.

In presenting the cases, Dr. Morrow said that some of the lesions were analogous to those seen in Dr. Fox's case just shown. He had made a provisional diagnosis of eczema. The best results had been obtained from the external use of benzoated collodion.

DR. BRONSON believed it to be a case of eczema arthritogenetica described by Bazin, as the patches were sharply circumscribed, dry, and no tendency to spread.

DR. FOX thought the lesion was an eczema; in some places there was a number of vesicles in groups resembling greatly dermatitis herpetiformis.

DR. ALEXANDER had seen the case in the hospital, and at first thought the eruption under the left nipple was psoriasis, but after a time, because of the greasy appearance of the scalp, he considered it seborrhœa.

DR. MORROW showed a

CASE OF ECZEMA OF CICATRICAL TISSUE.

The patient, an Italian, five years ago received a cut on the arm, above the wrist, from an axe. The arm became painful, there was swelling, and abscesses formed, which were opened. Now there is a development of eczema over the inner, outer, and anterior aspect of the right forearm, chiefly situated upon cicatricial tissue.

DR. BRONSON said that he had seen a similar case, in which a man received a punctured wound; there was considerable loss of tissue, attended by œdema, which was probably due to the obstruction of the lymphatics. There was a copious secretion, and a condition resembling eczema madidans resulted. He thought that the lesion in Dr. Morrow's patient might be due to an obstruction of the lymphatics.

DR. ALLEN exhibited a

CASE OF TYLOSIS.

The patient was first seen in February, 1883, when she was suffering from anidrosis of the palms, the hands were calloused and fissured, and presented very much the appearance of an eczema. Now on the palms and back of the hands, as well as the forearms, the wrists, and around the ankles, are deep sago-like granules, and when left without treatment the epidermis becomes quite thickened and horny. The eruption never itched.

DR. BRONSON presented a

CASE OF ATROPHIA CUTIS PROPRIA.

Janet M., aged 4 years. The child has always been healthy, and there is no history of eruption in the family. The lesion was first noticed last January on the temple. At first it was red and a little swollen, but soon became white. Soon after this, spots were seen on the neck, supposed to be a loss of pigmentation caused by sun-burn; later, similar white spots on the back and chest were noticed.

Now, just above and anterior to the left ear is a spot about the size of a new five-cent piece, slightly depressed, and with a faintly marked reticulation, rather sharply defined, and of a dead-white color. The skin feels hard, and is not freely movable over the underlying surface. Extending from an inch below the left ear, along the junction of the neck with the chin, is a stripe about half an inch wide that reaches across the median line, and gradually disappears, fading away about two or three inches from the right ear. Its surface is smooth, shiny, and glossy as if glazed with a thin varnish. Its color is dead-white, especially toward the middle. At the lower border there is a marked increase of pigmentation. At its upper border, the crease formed between the chin and neck is pinkish. There are two patches near the left shoulder blade, and one in the left lumbar region, larger and irregularly shaped, with spurs or lines running down from it resembling the lineæ albæ of pregnancy or obesity. There is another smaller spot on the upper part of the right buttock, and a small one on the lower border of the right shoulder blade. All of these patches show a white centre and general glazed appearance, while toward the periphery the color is pinkish or lilac-colored, showing the vessels coursing over it more plainly, evidently indicating a thinning of the opaque epidermis. The epidermis is nowhere altered, except a little roughened in one spot just scratched. The patches are not sharply defined, and the pink of the border begins at the white centre and shades off gradually into the surrounding tissue. The centre is apparently white because of the

atrophy of the vessels, and the lilac zone of the patches is more pronounced when the surface is exposed to the cold air. The veins, as they enter these zones, become decidedly more distinct, showing great translucency of overlying skin. The sensibility of the patches, so far as can be ascertained, is not noticeably altered, and when some of them are pinched between the fingers they seem a little thickened; the one over the temple is somewhat hard and hide-bound; that on the neck appears to be more resistant to the touch than the surrounding skin.

In connection with this case, DR. TAYLOR mentioned that of a woman, aged 36 years, whose husband had syphilis, and in whom the chest, arms, neck, scapula, and inter-scapular regions were covered with a typical morphea which had lasted for three years. There were twenty or thirty patches, varying in size from that of a half dollar to that of the palm of the hand, with violaceous borders and venules coursing through the patches. When the patches first made their appearance, they looked like erythema nodosum, and in the centre of each of these a whitening took place, and a violaceous border appeared.

DR. MORROW thought the case interesting and curious in its development. He did not understand whether the hyperchromia of the margin was due to a thinning of the skin or a hypertrophy of the cutaneous vessels.

DR. BRONSON said that his reason for exhibiting the case as one of idiopathic atrophy of the skin, and not as one of morphea, was to elicit an opinion. What constitutes morphea? This lilac border was due to a greater translucency of the skin in that situation; afterward, as the process goes on, and there is complete atrophy, we have a dead-white appearance. It is analogous to vitiligo, in which there is a heaping up of pigment at the edges of a patch. The small striations, seen in this case, were never found in morphea.

DR. PIFFARD asked if in this case, as in *striae atrophicæ*, infiltration had preceded the disease, and if atrophy preceded by infiltration constituted morphea.

DR. MORROW believed that in every case of morphea the structural changes were first hypertrophic, then succeeded by atrophy. Some writers classed morphea among the hypertrophies, others among the atrophies of the skin.

DR. FOX showed a

CASE OF PALMAR LESION.

The woman was shown at the Society about eight years ago. At that time the eruption presented similar appearances. Now there are several small points of eruption scattered over the palm of the right hand, and also on the fingers. The lesions present a great resemblance to syphilis. She has been under anti-syphilitic treatment without benefit. When she keeps her hands out of water the eruption is greatly improved. There is no eruption elsewhere.

DR. MORROW remembered the case as being under his care several years ago. He thought it remarkable that the lesions had remained so many years in the same form and in the same place.

DR. ROBINSON said that he was not prepared to call it syphilis; it might be an eczema or dermatitis.

DR. FOX said that the fact that it existed on one palm only and remained for twelve years was an argument against its being syphilis.

DR. ALLEN presented a

CASE OF ECZEMA.

Patient, a girl, was seen about two months ago for the first time. She then had an eruption of impetiginous eczema on the scalp, and the body was covered with scales. Now there are circular spots on the back and on the hands. In the centre of these patches the skin is healthy. There is also enlargement of the epitrochlear glands. The eruption made its appearance when the child was three years old, and has been present for the past six years. It was at one time supposed to be hereditary syphilis, but there is no history pointing to that. The

eruption on the scalp has disappeared under the use of carbolized oil, and the body has been dusted with starch powder. Internally, antisyphilitic treatment had been employed. The question was raised whether the enlargement of the epitrochlear gland could occur if syphilis were not present.

DR. KEYES did not think that because a lesion disappeared under the use of an antisyphilitic treatment it was necessarily syphilis. He had also found enlargement of the epitrochlear gland in the acute stage of suppuration, due to the spontaneous formation of an abscess.

DR. KEYES then showed a

CASE OF DISEASE OF THE NAILS.

The patient was a medical student. Eight years ago he had a patch of dry eczema on the back of the right hand. This remained one year, and finally disappeared under the use of mercurial ointment. The present malady came on the palm of the same hand, simply as a drying up of the epidermis with the appearance of scattered small round white areas, where evidently the skin is elevated with air beneath; there has never been any fluid present. The epidermis of the palms sheds off in pieces from time to time. All the nails of the right hand became affected, as at present, viz., a thickening of the matrix appeared beneath the free border of the nail, which apparently spread backward beneath the nail, and there showed through as chalky areas, leaving the glistening polished surface of the nail above the altered patch unchanged. There is also a ragged condition of the nails. The nails of the left hand are normal. The nails of some of the toes are similarly affected, but to a lesser degree. Occasionally, also, eczematous patches appear about and between the toes. The rest of the skin is in good condition. The general health is good. The present malady has remained practically unchanged for the past seven years. The patient's grandfather had a similar condition of the nails.

DR. ALLEN then read the paper of the evening, entitled :

SOME OF THE USES OF PYROGALLIC ACID IN DERMATOLOGY AND THE DANGERS ATTENDING ITS APPLICATION.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

PRICKLY HEAT—RECURRENT HÆMATEMESIS WITH URTICARIA—BILATERAL HERPES ZOSTER—ECZEMA FOLLOWING THE COURSE OF NERVES—PITYRIASIS MACULATA ET CIRCINATA—LUPUS—TREATMENT OF VASCULAR HYPERTROPHY OF THE NOSE—TURPENTINE INTERNALLY IN CUTANEOUS DISEASES—ANTIMONIAL WINE IN SOME SKIN DISEASES—COCAINE IN PRURITUS ANI.

Prickly Heat.—The following case has been recorded by Mr. Wharton as an example of "Prickly Heat" (*Lancet*, August 2, p. 190), a tropical disease which, he thinks, may occur in this country. A medical man, after passing the age of 30, and while in perfectly good health, suffered from continually increasing distress as each summer came round, owing to a papular eruption over the whole of the

back, and in considerable patches on the forearms; the eruption was accompanied by much "prickling," always increased by perspiration, and no treatment was of the least benefit, the eruption continuing from May to November. At last Mr. Wharton thought that perhaps the light short-sleeved gauze vests that the patient wore during the summer might have some share in causing the complaint, as they were too thin either to absorb sweat or to protect from sudden chills; he was therefore advised to wear throughout the summer the same thick, long-sleeved woollen vests which he wore in winter, with the happy result of complete cessation of the affection during the whole of one summer.

Recurrent Hæmatemesis with Urticaria.—Dr. Pringle communicated the following remarkable "Case of Recurrent Hæmatemesis with Urticaria," to the Clinical Society on January 9th: A gentleman, aged 51, with a good family history, suffered in 1872 from two attacks of ordinary urticaria. Several similar attacks occurred in 1878, and in 1879 they were very frequent and severe, the tongue, mouth, and fauces being involved, and a watery fluid vomited; in 1880, he was never free from urticaria, and at intervals of about two months he had very severe attacks, with vomiting, often lasting twenty-four hours at a time, and much blood. The attacks became less frequent, but more severe in 1881 and 1882, and in November, 1882, the blood vomited in one attack filled two hand-basins, besides saturating the bed. The next attack occurred in April, 1883, when he was seen by Dr. Pringle, who found bright pink wheals, nowhere purpuric, thickly studded over the trunk and extremities; the blood vomited filled a large hand-basin; recovery ensued, the patient, as was always the case, getting well very rapidly. Soon afterwards he had two unequivocal attacks of gout in the right foot and left hand, and subsequent urticarial and vomiting attacks were less severe and frequent, and better controlled by subcutaneous injections of morphine and ergotin; three days after an arrested attack, a copious tarry motion was passed. The immediate exciting cause of the attacks was nearly always exposure to cold, and during the intervals he was free from all pain, and other symptoms of gastric disorder or ulcer; the liver and spleen were of normal size, both during and between the attacks; the urine passed during the attacks never contained blood, and in the intervals was often loaded with urates, and contained an excess of uric acid, but no albumin nor sugar; the radial pulse was hard, and the second sound of the heart sharp at the base. Dr. Pringle believed that the hæmatemesis was due to capillary rupture, occurring when the gastric mucous membrane was in an urticarial condition. No exactly similar cases had been described, but Murchison had mentioned the case of a boy with urticaria tuberosa, purpura, and hæmorrhage from the bowels, kidneys, and urinary passages, accompanied by discharge of much uric acid.

Bilateral Herpes Zoster.—"A case of Double or Bilateral Herpes Zoster" has been narrated by Dr. Finny (*Brit. Med. Journ.*, Jan. 10, p. 67). A married woman, aged 40, had severe headache for four days, depriving her of sleep; pain extended all over the head, but was most severe on the right side; at the time of its first appearance she noticed a number of small red spots on the left side of the neck and shoulder, which were the seat of burning and soreness, and increased in size and number. At the same time the right ear became sore, and painful spots broke out through the hair on the back of the scalp on the right side. On inspection, characteristic erythematous patches of zoster, studded with vesicles of various sizes, were at once recognized, both sides being simultaneously affected, although at a somewhat dif-

ferent level: on the left side the symptoms chiefly followed the distribution of the descending sensory nerves of the cervical plexus, and were nearly limited to the upper part of the deltoid and pectoral muscles; while on the right side no patches occurred below the level of the thyroid body, the neck, face, ear, and scalp being the parts affected, corresponding to the distribution of the ascending branches of the second and third cervical nerves, the junction of the superficialis colli with the facial, and the greater and lesser occipital nerves. The chief interest of the case is that both sides were attacked at the same time, which is extremely rare.

Eczema Following the Course of Nerves.—Dr. Shearer has published an account of "A Case of Eczema following the course of the small sciatic and short saphenous nerves" (*Glasgow Med. Journ.*, Feb., p. 81). A thin healthy boy, aged 13, noticed, eighteen months before he was first seen, that the skin behind the left knee-joint became thick, rough, red, and itchy; this condition slowly extended downwards to the prominence of the calf, and upwards to the buttock, and within the last six months or so had spread still farther downwards to the little toe, and had undergone little or no change for four or five months. While spreading it was red, itchy, and "leeted a good deal." When seen, the eruption was dark-red, in many parts covered by thin scabs raised above the general surface of the skin; the margins were well-defined, and it extended in one unbroken band from the buttock to the toe, the neighboring skin being perfectly healthy; the breadth varied from a little more than a quarter of an inch to two inches, being broadest over the buttock; there were one or two outlying patches over the popliteal space and calf; the eruption was much furrowed, and its margins everywhere marked by a narrow bronzed line of discoloration. Treatment was unavailing, and about a month later the eruption assumed a warty character for about two inches above the heel, and was much elevated, dried, and cracked just above the insertion of the tendo Achillis. About the same time an attack of herpes zoster began to develop on the opposite thigh and hip, which ran their usual course. Dr. Shearer points out that the curious affection of the skin in this case corresponds roughly to the course of the main trunks of nerves, and considers, therefore, that the cutaneous twigs were not in themselves primarily affected.

Pityriasis Maculata et Circinata.—Writing "On the Disease of the Skin named Pityriasis Maculata et Circinata" (*Lancet*, Sep. 20, 1884, p. 185), Dr. Colcott Fox states that it has not hitherto been described in England. He refers to Duhring's paper (1880), and considers that the affection was first described by Gibert as pityriasis rosea (1860), and further by Bazin (1862), Hardy (1868), Horand (1875-6), and Vidal (1877). Dr. Fox has recognized five cases, of which he recites that of a child (Blanche) already recorded in this JOURNAL (April, p. 102) by Dr. Kinnier. He finds that the macules may evolve primarily on the limbs or trunk, that the eruption bursts out in profusion and acutely, and continues in a lessening degree for several weeks; he has not noticed (with Gibert and others) that it always begins on the chest, and fades on older parts pari passu with its extension elsewhere; he describes the eruption as consisting of small rosy macules, and notes that while fading it resembles tinea versicolor; he points out the distinction from psoriasis, and that it is not parasitic. It is not the same as the roseola annulata of Willan, but often strongly suggestive of roseolous syphilides, especially the tardy circinate variety.

The same subject was brought before the Clinical Society by Dr. Fox, on April 10, as "A Peculiar Form of Skin Disease." He also noticed the parasitic

form described by Vidal, and showed a specimen of the fungus (*Microsporon dispar*). Dr. Stephen Mackenzie considered this only a micrococcus, which might occur in any necrotic tissue. Mr. Jonathan Hutchinson thought these cases, which always began on the trunk, never on the limbs or palms, originated in articles of clothing worn next the skin too long, and had recommended silk instead of flannel vests, and had seen the eruption disappear without further treatment.

Lupus.—The subject of lupus has been considered in a variety of communications, chiefly bearing on treatment. In a "Narrative of an Instance of Cure of Lupus erythematosus" (*Brit. Med. Journal*, March 14, p. 535), Mr. Jonathan Hutchinson relates the case of a gentleman, aged 45, whom he first saw in 1881, with characteristic patches of erythematous lupus on each side and on the ridge of the nose. He was in fairly good health, but had a feeble circulation and dusky ears. His skin had always been very irritable, and the lupus patches had been present about a year. Arsenic was given internally, and a weak lotion of tar and lead to bathe the patches. In 1883 his medical attendant wrote to say that he was worse, and it was decided to insist on the use of arsenic. In February, 1885, the patient called to say his lupus was quite well. White, thin, inconspicuous scars had taken the place of the former patches. The patient stated that his cure was unquestionably due to the arsenic, which was not at first taken regularly, but had been continued since 1883 for fifteen months; it caused a sharp attack of shingles, and made the eyes red and irritable, but in the end quite cured the lupus. It did not appear that any local remedy had been employed. Mr. Hutchinson has prescribed arsenic for many other cases of lupus erythematosus, but has never realized any definite result; perhaps it may have seldom been sufficiently pushed. The present case would certainly suggest a freer use of the remedy, but he fears that we shall find that it is by no means generally successful.

Dr. Matthews Duncan's paper on "Lupus of the Pudendum," has already found a place in this JOURNAL (April, p. 116). The same author has also written "on Hæmorrhagic Lupus of the Female Genital Organs" (*Edinburgh Med. Journ.*, July, 1884, p. 5). The paper is chiefly of gynecological interest, and contains an account of four cases. He designates the disease "lupus" in accordance with general practice, but histological examination shows that it has not the same structural peculiarities as lupus elsewhere. There are many varieties: patches of redness, uniform or nodulated, hypertrophies, ulcerations, and inflammations; there is generally no increase of sensitiveness, and in ulcerations sensation is diminished; sometimes, however, the affected parts are extremely sensitive, especially when inflamed. The special character of the four cases given is bleeding, either slight and of long or short duration, or profuse and of short duration; in one case slight hæmorrhage lasted fourteen years; in another it was so sudden and profuse as to cause alarming faintness; in two cases the ulcerated surfaces bled freely on being touched, but in the case where it was most copious the parts did not bleed on repeated handling. Dr. Duncan considers that the disease is allied with a form of chronic vaginitis seen mostly in women after the menopause, and called senile.

A valuable paper on "Lupus and its Treatment" was read before the Academy of Medicine in Ireland, on December 19, 1884, by Dr. Walter Smith (*Dublin Journ. Med. Science*, February, p. 89). He found the frequency of lupus in Ireland to be 1 in 200, while in England and Scotland it was about 1 in 50 cases of skin disease. He reviewed the arguments in favor of its tubercular origin, and believed it was produced by an organized virus. Clinically, many observers had

recognized points of contact between scrofula and lupus, and had noted the frequent association of cheesy affections of the glands and joints with lupus. Besnier had found that of thirty-eight lupus patients, eight had well-marked physical signs of phthisis. Histologically, the close resemblance between a caseating miliary tubercle and a lupus-nodule had been often pointed out; recently Koch had found tubercle-bacilli in four excised bits of lupus skin, but found them only in giant-cells, and very sparsely distributed. Experimentally, both culture and inoculation experiments had yielded positive results. As to treatment, it was pointed out that if the tuberculous doctrine were accepted, it strengthened the position of those who advocated constitutional treatment, and especially antistrumous remedies; the different plans of local treatment were referred to, particularly linear scarification and erasion.

Dr. Stowers, writing on "the Treatment of Lupus" (*Brit. Med. Journal*, January 3, p. 11), has observed most satisfactory results from the combined use of the scoop and nitrate of silver. Volkmann's spoon, when applied with considerable force, breaks down and removes all diseased tissue, while the healthy structures are too tough to be injured. The operation should be performed under an anæsthetic, as much depends on the complete removal of every tubercle: after bleeding is arrested, the serous discharge from the wound should be soaked up with blotting paper, and then solid nitrate of silver applied, being pushed deeply into the holes and interstices left by scraping. The parts should be dressed with lint saturated with carbolized oil, and more oil allowed to run under the dressing next day, and when suppuration has commenced, carbolized oil dressings should be applied daily; when the sloughs are separating, carbolic lotion should be used for cleansing. The operation has to be repeated at intervals of six to eighteen months, sometimes several times.

"The complete destruction of disseminated patches of lupus vulgaris by a new double-screw excavator," is recommended by Mr. Malcolm Morris (*Lancet*, July 26, p. 141), who says that surgeons who have practised scraping, or scarification, or both, are often disappointed to find small isolated tubercles reappearing in the scar or in the margin of the patch; these are difficult to remove by the above process, but it is essential that they should be destroyed. To accomplish this, an instrument should be somewhat larger than the tubercle, so that when inserted it may firmly grip the surrounding tissue; it should possess many lacerating edges, whereby the nodule may be thoroughly ploughed up; and lastly, should be capable of rapidly penetrating to the bottom of the nodule. These requirements are attained by a double-threaded screw (which is figured), and the scar resulting from its use is pale, flat, and satisfactory.

Dr. Thin, continuing his comments "on certain new methods in the treatment of the diseases of the skin" (*British Med. Journal*, February 28, p. 423), points out that it is probably correct to say that there is no approach to unanimity as regards the methods generally applicable in the treatment of lupus. Scarification, at one time strongly advocated by Besnier, has now been superseded by another method, which is recommended with equal confidence. This has also been disappointed by scarification, as although great amelioration takes place, a complete cure is not often obtained. The foci of new growth, which continually reappear, require, as a rule, more energetic treatment. He then describes the "interstitial and discrete cauterization" by galvano- or thermocautery, which is now recommended by Besnier; the pyrogallic acid treatment as employed by Schwimmer, and the combination of scraping and pyrogallic acid, preferred by Dr. G. H. Fox, of New York.

Treatment of Vascular Hypertrophy of the Nose.—The following "Treatment of Vascular Hypertrophy of the Nose" is recommended by Dr. Stowers (*Brit. Med. Journal*, January 10, p. 68). In acute rosaceous acne, simple passive congestion with enlargement, or fibro-cellular hypertrophy, multiple punctiform scarification, by a special instrument with many small blades, gives good results. The nose should be fomented with hot water, held and compressed between the left finger and thumb, and rapidly punctured from base to apex. In three cases under treatment, for seven, seven, and five months respectively, the corresponding number of punctures in each case were 15,750, 11,150, and 52,200; usually from 500 to 3,000 are made at one sitting, at intervals of five days to a fortnight. The good results are attributable to local depletion, which allows the over-distended vessels to recover their tone, and to invisible scarring, which by after-contraction reduces vascularity.

Turpentine Internally in Cutaneous Diseases.—Among therapeutical papers, that by Dr. Crocker, "on the Internal Administration of Turpentine in Cutaneous Diseases" (*Practitioner*, March, p. 176) deserves notice. He believes that the turpentine reduce hyperæmia, and place the patient so far on the way to recovery that a short supplementary local treatment easily removes the remains of the lesion. He had used oil of turpentine as an external application for psoriasis for a long time in proper cases, and as he found that it also benefited parts of the eruption to which it had not been applied, he determined to give it internally. A case of an old man with general psoriasis of six years' duration is then described, who was given *ol. terebinth.* ℥ xv., gradually increased to ʒ i t. i. d. during a month, for the latter half of which two pints of barley-water were taken daily; there was no albumin in the urine, and he left the hospital improved. He was re-admitted in a few days, and the drug was then increased to ℥ lxxv. t. d. (!). This brought on slight hæmaturia, which subsided on stopping the drug. No external treatment was employed in this case, and the improvement was most remarkable, but the cure not complete. The turpentine was tried in thirty other cases, and, in a few, completely removed the psoriasis; but in most there was great improvement up to a certain point, when some external treatment was required to complete the cure. In two cases only the drug had to be discontinued from slight strangury, and in three cases diminished on this account; in all these the dose was under ℥ xx. In three cases the drug had to be stopped for dyspepsia, and in one it was left off because it had no effect on the disease. Thirteen cases of eczema were treated by turpentine, and some got quite well. Dr. Crocker thinks use of the drug should be restricted to those cases in which there is no defect of the general health, and finally notes that it appeared to relieve pain and retard growth in two cases of cancer. It is contra-indicated in the following cases: Children under five years old; all who have unsound kidneys or irritable bladders; most cases of dyspepsia, and gouty subjects. It should be given in emulsion three times a day after meals, the last dose not within three hours of bedtime, and barley-water should be given freely from the very commencement of treatment.

Antimonial Wine in Some Skin Diseases.—Writing "on the Use of Antimonial Wine for Certain Diseases of the Skin" (*Practitioner*, March, p. 161), Dr. Kent Spender remarks that as this drug has a marked influence on catarrh of the lungs or bronchi, it is reasonable to suppose it may control catarrh of the skin. He relates a case of psoriasis, threatening to pass into general exfoliative dermatitis, in which antimonial wine ℥ xv. was given every two hours during the day for a week, and then for another week ℥ xx.

every three hours, or six doses daily, and afterwards the same dose four times a day. The result was great improvement; in seventeen days only a dull, reddish maculation was left, and recovery was uninterrupted. Toxically, there was no evil effect whatever, nausea especially was absent, and no sensible physiological action was produced; the author believes that success was due to the administration of comparatively small and frequent doses.

Cocaine in Pruritus Ani.—Mr. Malcolm Morris, in a note on "Hydrochlorate of Cocaine in Pruritus Ani" (*Brit. Med. Journ.*, January 24, p. 177), relates the case of a gentleman who had long suffered from this distressing complaint. A solution containing twenty per cent of the drug, with five per cent glycerin, was ordered to be painted over the extruded mucous membrane and neighborhood of the anus, three times at intervals of ten minutes, the parts being allowed to dry somewhat before moving after the third application. As the result, the patient slept quietly for seven hours. This method was persevered in night and morning for more than a week without any return of the pruritus; it was then omitted for two days, and the irritation returned as bad as ever, while resumption of treatment again gave relief. Dr. Cottle (*Brit. Med. Journ.*, February 7, p. 278) has tried the remedy in the following two cases: (1) A lady with extensive lichen planus and severe irritation, preventing sleep without narcotics; all usual local remedies were without benefit. A four-per-cent solution of hydrochlorate of cocaine was freely and repeatedly applied to and around the spots, without relief. (2) A lady with severe eczema of the limbs of long standing, the parts being red, exuding, and partially excoriated; there was most intense itching unalleviated by ordinary measures; a five-per-cent ointment of hydrochlorate of cocaine in vaseline was freely and frequently applied, and rubbed in as firmly as tenderness of the skin permitted: slight diminution of the irritation followed. He thinks if it is to do good it should be dissolved in fat or oil, and the condition of parts should be such as to allow of firm rubbing in so as to favor absorption. CAVAFY.

LONDON.

Selections.

A NEW METHOD OF TREATING TINEA TONSURANS

THE difficulty of treatment is a purely physical one; namely, the almost seeming impossibility of bringing any active parasiticide into contact with the tinea fungus—the epiphyton or trichophyton tonsurans, whose conidia revel and run rampant in the secure nidus of the hair and hair-bulbs—a soil so congenial that it seems to be in some cases ever fertile and fertilizing.

Keeping this point in view, I made a large number of experiments with a variety of drugs—some of them so-called remedies—upon hairs, chiefly human and equine. I will not burden this meeting, nor waste precious time, by going into details; but I may mention that I steeped hairs in acetic acid and water, in spirits of turpentine, in chloroform, in sulphocarbolate of soda, bisulphide of carbon, glycerin of carbolic acid, solution of iodide of potassium, etc., keeping the hairs in the liquids for weeks and weeks—some of them for months—but they underwent no important change.

Knowing that hairs and most chitinous matters are acted upon by the caustic alkalies, I next tried these, and, of course, speedily ascertained that hairs were freely soluble in them. I have complete solutions of hairs in liquor potassæ and liquor sodæ. But these alkalies, although they will dissolve the hairs, are not competent to destroy the activity of the conidia of the ringworm-fungus; and the next step was to make the potash-solution (I took this for preference) convey a conidia-destroying agent

I made another series of experiments on hairs, and also upon the common mould or fungus—the penicillium. I cultivated the fungus on damp corks, and then treated these corks with various applications. Wiping away a portion of the propagated fungus very carefully, and taking sketches of the denuded portions and the remaining fungus-covered parts, I applied to the denuded surfaces the following solutions: to some, liquor potassæ; to others, liquor potassæ containing some iodide of potassium; to others, glycerin of carbolic acid; to others, solution of bichloride of mercury; and to the remaining corks two solutions, the first containing liquor potassæ and iodide of potassium, and then a second solution containing perchloride of mercury dissolved in spirits of nitric ether. The important outcome of these experiments was this; namely, that, where the last two solutions had been applied, no fungus-growth occurred again on the surface of the corks, even when months had elapsed; the soil, in short, had become uncongenial.

I next made experiments upon pieces of soft wood, and upon hairs pressed firmly between two pieces of leather, to ascertain the penetrating powers of different solutions; or rather, I was working this out alongside with the last-mentioned series of experiments—for to be effective, remedies must, according to my theory, reach the roots of the hair. I came to the conclusion that with liquor potassæ containing iodide of potassium in solution, and then afterwards applying mercuric chloride dissolved in spirits of nitre, I obtained the best results. I used spirits of nitre, because this forms a very thin and mobile liquid. These results seemed to show that the most powerful combination of remedies was first of all the application of liquor potassæ containing in every ounce half a drachm of iodide of potassium; and, secondly, a solution of perchloride of mercury in spirits of sweet nitre, in the proportion of three grains to an ounce, or an aqueous solution of the mercuric chloride. . . . To summarize, I may state that I have treated about thirty cases in all, and with very good results: and, in addition, I have satisfactory statements from a few friends to whom I have confided my method.

The great feature which I contend for in my plan is that, by softening the hairs with liquor potassæ, the iodide of potassium is conveyed to the very hair-roots and bulbs, the spots where the conidia flourish and germinate in profuse abundance, and hitherto in comparative security. There, whilst the hairs are in a softened condition, the mercury-solution can penetrate, and then, coming into contact with the iodide deeply down, an important chemical action is set up, and biniodide of mercury is formed, just where it is most especially wanted.—A. J. HARRISON, *Brit. Med. Journal*, Sept. 5, 1885.

THE TREATMENT OF TINEA.

It may be concluded from this very brief consideration of the subject:

1st. That it is highly probable that alopecia areata may be a parasitical affection, as has been partially demonstrated by the microscopical investigations of Malassez, G. Thin, Lehlen, Eichhorst, Pellizari, etc.—or at least that there is in-

contestable clinical evidence in favor of its contagiousness—but that there are other species of alopecia areata, which are totally different, in respect to their mode of development, tendency to relapse, hereditary transmission, and non-contagiousness.

2d. That a correct diagnosis in cases of tinea is important for prognostic purposes, and also as determining the appropriate treatment, which, in any case, ought to produce no symptoms more serious than those which would result from the disease when left to run its own course.

3d. That prophylactic measures, judiciously applied, wherever children are crowded together (in families or schools), tend to diminish day by day the total number of sufferers from this malady. Keeping the hair cut very close, washing the head from time to time with soap, and when the disorder has been contracted, isolation of the patient and all his belongings, including the head itself by means of a cap, together with rigorous inspection of schools—such are some of these measures, whose good results are every day apparent.

4th. That, historically considered, the treatment of tinea (first established on a scientific basis by the discoveries of Schoenlein, Gruby, and Malmsten) may be divided into two epochs—that, now past and gone, in which it was conducted according to the principles of the humoral pathology; and the present, when we confine ourselves entirely to local measures. Between these, Bazin occupies the period of transition.

5th. That epilation, the pitch-cap, etc., etc., are processes which have come down to us from antiquity; that it is Bazin's chief merit to have recognized the advantages of the first, while he rejected the second, and also to have advocated the topical use of parasitocides.

6th. That the duration of treatment is in no degree lessened by the employment of the so-called parasitocides, and that when the eclectic method is resorted to (comprehending epilation, *zones de surveillance*, shaving the head, and the use of expulsive agents), from six months to two years are required for the cure of trichophytosis and favus, and from two to six months for the cure of alopecia areata; this implying merely the removal of the local symptoms, without regard to the occurrence of relapses. As to alopecias of nervous origin, or constitutional, their period of duration cannot be foretold with precision, since it is sometimes indefinite.

7th. That, before pronouncing the cure complete, after the hair has begun to grow again, the latter, together with the scratched-off epidermis, should be kept under microscopical examination for a certain length of time.

8th. That parasitocides, in reality, have no existence, and that, as was well said by M. Besnier at the Academy of Medicine: All these dermatophytes are alike refractory to any substances employed at a strength compatible with the vitality of the organic elements they inhabit; all the morbid alterations which they produce are favorably acted on by a variety of remedies, but none of them is actually cured until the parasite has spontaneously arrived at its fullest development, or until its expulsion has been brought about by desquamative irritation of the layers of infiltrated cells; hence it is that the treatment of these alterations requires on the part of the practitioner adequate experience and a peculiar degree of care and watchfulness; and hence it is not to be supposed for a moment that any single agent, or any one systematic method, can be indiscriminately applicable to all cases and all subjects.—MANUEL J. VENEGAS Y CANIZARES, *Thèse de Paris*, 1885.

MERCURY AND ALBUMINURIA.

AT the congress for internal medicine, held at Wiesbaden in April, 1885, Dr. Fürbringer reported that he had found, out of a hundred chosen cases, eight syphilitics with perfectly healthy kidneys who developed albuminuria during mercurial treatment: the maximum of albumin being five per cent.

The internal and external exhibition of the mercury was followed by the same results which persisted during the whole of the treatment and disappeared some weeks after treatment was stopped.

The alterations in the kidneys were therefore not important, as was proven as well by microscopic examination.

In another series of one hundred cases of syphilis which had not been treated with mercury, or were no longer so treated, and in which the kidneys had been healthy, he was able to establish in twelve per cent an albuminuria consecutive to the syphilis.

This in every case was discovered in the stage of the roseola eruption. Here the urine contained formed cylinders which pointed to a light nephritis. This form of albuminuria gave way to mercurial treatment. Therefore he argues that the existence of albuminuria is not a contra-indication to mercurial treatment, which, on the contrary, should be prescribed as a necessity.—*L'Abeille Médicale*, Sept. 7, 1885.

TREATMENT OF PSORIASIS BY MEDICATED PLASTERS.

THE medicated plasters constitute a neat and convenient method for the treatment of psoriasis, which has an additional advantage in that it may be carried out by the physician himself.

The applications require to be renewed less frequently than when simple unguents are employed. They are usually contra-indicated if the disease is seated on the face or scalp.

The chrysophanic plasters appear to be as efficacious in cases of psoriasis as the ointment compounded of the same agent, while unpleasant symptoms are less liable to be occasioned by their use. The average duration of treatment with the plasters is about three weeks.

They exert no influence in the prevention of relapses.

Pyrogallic acid plasters are less serviceable than those of chrysophanic acid.—J. BELLAN, *Thèse de Paris*, 1884.

Received.

L. DUNCAN BULKLEY, A.M., M.D. Acne: Its Etiology, Pathology, and Treatment. G. P. Putnam's Sons, New York. Will be noticed in next number.

P. G. UNNA. Clinical History and Treatment of "Lichen Ruber."

———— Die neueren Fortschritte in der Therapie der Hautkrankheiten.

———— Die Nervenendigung in der menschlichen Haut.

———— Ueber medicinische Seifen.

———— Heilung eines Falles von Lepra tuberosa.

———— Die Stauungsdermatosen des Unterschenkels.

R. B. MORISON. Ergebnisse der Behandlung von Hautkrankheiten mit Unna'schen Präparaten.

GREENOUGH. Five cases of Cerebral Symptoms in Early (secondary) Syphilis. (Reprint.)

————— Clinical Notes on Psoriasis. (Reprint.)

————— The Routine Treatment of Venereal Diseases. (Reprint.)

Items.

SYCOSIS TREATED WITH OLEATE OF COPPER.—Dr. S. Armer reports that he cured himself of a sycosis from which he had suffered for twenty-five years, with a twenty-per-cent ointment of oleate of copper. The duration of treatment was only four weeks.—*Therapeutic Gazette*, Oct., 1884.

TINCTURE OF PULSATILLA IN THE TREATMENT OF ORCHITIS.—Martel de St. Malo, in a correspondence with Dujardin-Beaumetz, reports satisfactory results from the use of pulsatilla in epididymitis. He refers to its successful use in America.—*Bull. Génér. de Thérapeutique*, Feb. 15, 1885.

THE CURETTE IN THE TREATMENT OF SYPHILITIC LESIONS.—M. Spillman (de Nancy) has recourse to scraping with the curette of Volkmann, and the subsequent dressing of the wound with the *liqueur de Van Swieten* (Hydrarg. Bichloridi, 1 pt.; Alcohol, 100 pts.; Distilled Water, 900 pts.) in the treatment of old serpiginous ulcerating syphilides, and of phagedenic chancres. In five cases in which he had occasion to practise this treatment, he attained a prompt and permanent cure.—*Le Progrès Médical*, Sept. 5, 1885.

TREATMENT OF ERYTHEMA NODOSUM.—The raised patches of erythema nodosum which are sometimes found over the tibiæ are sometimes very painful, and usually slow in receding. I have acted in accordance with the view that this disease is due to inflammation of the lymphatic vessels and spaces, and that it is more closely allied to erysipelas than any other disease; I have, therefore, treated it antiseptically with sulphurous acid. In three cases treated in this manner, I have met with marked success, the pain being relieved and the patches rapidly subsiding. My method is to soak lint in a mixture of equal parts of fresh sulphurous acid of the British Pharmacopœia and hot water heated to boiling point; the lint is then wrung out and placed over the patches. When it cools, it is changed for another piece.—W. E. BUCK, M.D., *Brit. Med. Journal*, No. 1,278, 1885.

THE TREATMENT OF FROST-BITTEN FINGERS AND TOES.—Dr. Lapatin, in the *Proceedings of the Caucasian Medical Society*, advises that fingers and toes which have been slightly frost-bitten, and which subsequently suffer from burning, itching, and pricking sensations, should be painted, at first once, and afterwards twice a day, with a mixture of dilute nitric acid and peppermint water in equal proportions. After this application has been made for three or four days, the skin becomes darkened and the epidermis is shed, healthy skin appearing under it. The cure is effected in from ten to fourteen days. The author has found this plan very effectual amongst soldiers, who were unable to wear their boots, in consequence of having had frozen feet. They were, in this way, soon rendered capable of returning to duty.—*Brit. Med. Journal*, Sept. 5, 1885.

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Dr. Jackson's case of Dysidrosis.

1

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A CASE OF DYSIDROSIS OF THE FACE,

BY

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ON the 13th August, 1885, Mrs. K., presented herself at the New York Polyclinic for treatment of a chronic eruption on the face. The following is a report of the case.

Mrs. K., born in Ireland; age 45; widow; cook. Her general health is excellent. She never has been sick a-bed a day in her life, excepting after parturition. She has had five children. During the past few weeks she has had some slight rheumatic pains in the knees and legs. She is stout, and her skin is soft and smooth. Her tongue is slightly coated, but otherwise there is no evidence of dyspepsia. Her bowels are regular, appetite good, and apparently she is in a good physical condition. Her present trouble began five years ago. It is worse in summer than in winter, and particularly when she is much over the fire, but *it has never been entirely absent* since it began. Except this present disorder she never has had any skin disease.

The eruption is located upon the face, occupying the lower half of the forehead, surrounding both orbits, occurring below both eyes, and on the sides and bridge of the nose, and running down on each side of the nose for a short distance on the upper lip. It has the appearance of large and small sago grains scattered over the affected parts, and consists

entirely of fully distended vesicles with clear contents. The largest vesicles are about the size of a split French pea, the smaller ones are of the size of a pin-head. They are generally discrete, though here and there closely crowded together. A few have apparently joined at their edges, and some of them are of a darker shade than the others. Central puncta are visible in a very few. When pricked, a clear fluid with acid reaction escapes from them. They do not rupture of themselves, and their covers offer considerable resistance to the lancet. The skin, otherwise, is perfectly normal, and free from any appearance of inflammation. When slightly rubbed with a handkerchief the skin becomes easily hyperæmic. There are a few dilated blood-vessels upon the nose.

The only subjective symptom is slight itching at times.

The diagnosis of this case lies between eczema, herpes, sudamina, and dysidrosis. At first glance eczema vesiculosum would naturally suggest itself. But eczema is a disease in which the vesicles tend to break down of themselves very soon after their formation, and to leave a moist exuding surface. Then, too, the vesicles of eczema are of pin-point to pin-head size, of pretty uniform dimensions in the patch, contain a clear watery fluid of alkaline reaction, show by the redness of the skin upon which they are seated their evident inflammatory origin; and the pruritus accompanying them is pronounced. The patches they form are of undetermined outline, with outlying vesicles in the neighborhood. So that in this case that diagnosis can be readily excluded.

In herpes, while the vesicles do not tend to rupture, they show a decided tendency to group themselves in well-defined patches. In herpes febrilis they are most commonly seen about the mouth and nose; in zoster they occur along the course of the branches of the trigeminal nerve, usually on one side of the face, and rarely symmetrically. In both forms of herpes there is more or less pain, of a burning character in herpes febrilis, and neuralgic in zoster. Both forms are very acute. The fluid in the vesicles is at first clear, later turbid, and always of alkaline reaction. These characteristics are so markedly different from what obtains in our case, that we may readily discard the diagnosis of herpes.

Between sudamina and dysidrosis the diagnosis is not so easy. The meaning of the term "dysidrosis" is difficult sweating. As the acid reaction of the fluid in the vesicles of our case pretty clearly indicates that the disease has a close relation with the secretion of sweat, and as, further, the disease is aggravated by exposure to heat, it would seem that dysidrosis would be an eminently correct name for the disease. But that name has been applied by Dr. Tilbury Fox in 1873, to a well-marked disease occurring upon the hands and feet, and in the literature of the subject I have been unable to find the record of any case in which it affected the face.

As described by Fox,¹ dysidrosis is an acute affection of the sweat glands and ducts which gives rise to an eruption of, at first, deep-seated vesicles upon the palmar surface of the hand, between the fingers, and upon their palmar surfaces. Soon the vesicles enlarge, and appear as sago-grain-like masses with, in many cases, a minute white speck in their centre, the opening of a sweat duct. In mild cases this may be the end of the process, and in a few days the whole disease may disappear with some slight scaling of the affected part. The disease is very itchy. It is not uncommonly met with. In more severe cases the vesicles become larger, and some may run together and form bullæ. The contents of the bullæ disappear by absorption and evaporation; their covers fall, and leave a reddened surface, which is dry. The reaction of the fluid of the vesicles is acid. Either of these forms may attack the feet, and not infrequently there will be a general eruption over the body of miliaria or lichen tropicus. The disease is induced or aggravated by excessive sweating, occurs in debilitated or nervous subjects, and is exceedingly apt to relapse. The whole process runs its course in a few weeks at the outside, often in ten days. Fox regards the disease as a neurosis, producing paresis of the sweat glands, and believes that the vesicles are produced by retention of sweat.

Crocker² made a number of sections of the diseased skin at various periods of its course, and reported the result of his investigation to the Pathological Society of London, in 1878; at the same time showing his drawings of the microscopical appearances. He found in the early stage of the eruption that there was no change in the horny layer of the skin, but there were loculi in the rete, and that these were interpapillary. The capillaries of the papillæ were apparently normal. The sweat ducts were very distinct in some sections throughout their course, and the sweat glands were apparently swollen and somewhat infiltrated. The capillaries of the corium, especially those that ran to and from the sweat apparatus, were here and there somewhat large and distended. The largest vesicles were formed by the coalescence of several smaller ones. The bullæ that formed were loculated. In no case were vesicles formed in connection with blood-vessels, or escape of fluid from them. He believes that, anatomically, the disease is an inflammatory affection of the sweat apparatus in which the ducts in the Malpighian layer probably became choked, certainly distended. This is followed by escape of fluid into the surrounding tissues, producing the characteristic vesiculations which are, at first, imbedded in the skin, and afterwards, in consequence of increase of the effusion, enlarge so as to cause an uplifting of the cuticle and the formation of loculated bullæ.

¹ Amer. Jour. Syph. and Derm., 1873, iv., 1.

² Trans. Path. Soc., London, 1878, xxix., 264.

Hutchinson,¹ in 1871, described the same disease in a clinical lecture, and called it "cheiro-pompholyx," a misnomer, as the disease occurs on other parts of the body besides the hands. He regards it as a neurosis occurring in nervous subjects, in no wise connected with the sweat apparatus, though in some cases produced by the action of high temperature.

Robinson² also described the disease in 1877 under the name of "pompholyx." He believes that the disease is a neurosis, and that the vesicles have an origin similar to those of herpes, especially of those of herpes progenitalis. From his study of the microscopical anatomy of the malady, he is led to hold that it has nothing to do with the sweat glands, and that the fluid of the vesicles is at first pure serum, coming from the papillary vessels, which, passing through and between the lower cells of the rete, collects in different situations to form the vesicles. He found the sweat glands to be normal, and their ducts were not distended. In one section the sweat duct was the principal structure separating two vesicles. The reaction of the fluid contents of the vesicles in his case, as in Hutchinson's, was alkaline.

When careful investigations by such competent observers give such opposite results, it is difficult to avoid the inference that they, perhaps, were studying different diseases. We cannot at present regard the matter as settled, and must await further studies in this direction.

Sudamina, sudamina crystallina, or miliaria crystallina, is an affection of the sweat glands, of non-inflammatory character, in which superficial, clear, dew-drop-like vesicles appear, which are of various sizes. The eruption is met with in many febrile diseases, in cachectic conditions in which excessive sweating takes place, and in some individuals, especially those who are fat or feeble, who are subject to profuse sweating from any cause. Its favorite locations are the face, chest, abdomen, axilla, and groin. Its duration is from a few days to two or three weeks. Robinson mentions a form of the disease which occurs especially on the nose, forehead, and cheeks of women, such as washerwomen who are exposed to the combined action of exercise and vapor. In this form we have a sago-grain-like eruption caused, as shown by microscopical examinations of sections, by retention of sweat in the sweat ducts in the corium, due to a stopping up of the duct by detached epithelium. The duct becomes enormously dilated. The facility of distention of the duct is aided by a loss of tone of its wall, consequent upon circulatory disturbances.

This form of sudamina has many anatomical features similar to those found by Crocker in the milder cases of Fox's dysidrosis, such as the dilatation of the sweat ducts, and the source of the fluid in the vesicles from the accumulation of sweat, and not from the blood-vessels. In their

¹ *Lancet*, 1876, i., 630.

² *Archives of Derm.*, 1877, iii., 289.

symptoms they differ. The one has clear, dew-drop, prominent vesicles throughout its course, and is accompanied with very slight pruritus. The vesicles of the other are deep seated, are apt to develop into bullæ, and are very itchy. The one is located on the hands and feet. The other is peculiar to the face.

Our case certainly corresponds in its location, appearance, and etiology to the sudamina of the face of Robinson, and is doubtless the same disease. While exceedingly unwilling to introduce a new element of confusion into our already confused nomenclature, I have nevertheless chosen the designation of dysidrosis for our present case, because it is descriptive of the disease; a "difficult sweating" of the face. Dr. Robinson in the discussion of his paper on "Miliaria and Sudamina"¹ speaks of the condition as a true dysidrosis. For the "dysidrosis" of Fox, and the "cheiro-pompholyx" of Hutchinson, it would, perhaps, be well to adopt the name of "pompholyx," as suggested by Robinson.

CASE OF TYLOSIS (CALLOSITAS) OF THE HANDS.²

BY

ROBERT B. MORISON, M.D.,

Professor of Dermatology and Syphilis in the Baltimore Polyclinic.

AN unusual form of this disease presented itself at the Polyclinic in Baltimore last spring. In its way it was the most aggravated case I have ever seen, and in one particular it was unique, *i.e.*, in the entire absence of pain, notwithstanding the amount of surface involved and the ulcerations following.

The patient was a negro man, æt. 32, of dark complexion, well made, tall, very muscular, and apparently healthy. He was a fireman on a steamer running between two ports on the Chesapeake Bay. The trip was made in a day and night—the firemen working four hours on and four hours off. He had been ten years at this work, shovelling coal into a hot furnace with his left hand on the lower part of the handle of the shovel, and his right grasping its upper end. The result of this action was a constant rubbing of the palm and fingers of the left hand up and down the handle of the shovel, and a prolonged exposure to intense heat of both hands. He wore leather gloves made without fingers, but which covered the palm and thumb of each hand, thereby protecting them to a slight de-

¹ Trans. American Derm. Asso., 1884.

² Read before the American Dermatological Association, August 27, 1885.

gree. The constant friction to which they were thus exposed gradually changed the whole contour of the left, and partly of the right hand. All the fingers of the left hand were affected. Two of them were actually worn off as far as the second joint, while the other two were gradually going in the same way, their nails having almost disappeared. The two entirely worn off presented the appearance of an onion cut into halves. There was a series of layers of thick, hard, lifeless epidermis arranged in concentric circles from the centre outwards. In the centre the sharp end of a piece of bone was visible. The man said he had only a few days previous picked out a piece of bone nearly an inch long from one finger and thrown it away. He felt absolutely no pain when he did so, nor had he suffered any from the fingers in which the disease had not progressed far enough to affect the bone. Several months before, a piece of bone from the other finger had been removed by a surgeon in a hospital, but the time he lost in healing the finger after the operation was the reason why he performed the second operation himself. After throwing the end of his finger into the fire, he continued his work, not even taking the trouble to dress the wound.

On the palm and in some other places besides the ends of his fingers, there were the same spots of hardened, thickened epidermis arranged in the same circular layers. On his left hand, where the inside of the thumb rubbed up and down the handle of the shovel, there was a large ulceration the size of a quarter dollar, from which he had picked the epidermis. Underneath was a raw, red, indolently granulating surface which was painless, and consequently he went on with his work rubbing the spot with the shovel as diligently as ever.

Such ulcerations in other places he had often had before on the hands and fingers, and they either healed over leaving a pigmented, smooth scar, the epidermis of which resembled that seen in ordinary callosities, or else they closed in gradually from the periphery, the epidermis piling itself up in layers over them, until they formed one of the spots already described.

The ulceration on the inside of the thumb, however, did not terminate in this manner. It went on granulating and being rubbed for a week, when the tissues became so thin, the ends of both bones of the first thumb joint could be plainly seen. In another week the bones were perfectly bare, they had become black—in other words, necrosed—and the man was waiting for them to drop out. Meanwhile, as the thumb was much weakened and the control of the joint was imperfect, the man had applied two splints of wood long enough to more than cover the joint on the upper and under surface of it. In this way the thumb was strengthened and was rendered, as he said, less “wobberly.”¹ Thus he went on

¹ The plates were kindly drawn and colored by my assistant, Dr. Keyser.

with his work almost as well as ever, nor was there any pain in either hand. He said he would not give up his work as long as he could handle a shovel because, firstly, he made more money at it than in any other way, and secondly, he would be pensioned if disabled.

I could obtain no plain history of syphilis from him, nor could I find any signs of it, such as scars or enlarged glands, upon his body, although he told me he had been given antisyphilitic remedies because other physicians thought the condition of his hands due to that disease. In this I could not concur, especially as the treatment was useless.

I gave him a pair of india-rubber gloves to wear while working, which softened to a degree the callosities, but which were not beneficial to the ulcerations. Recognizing the fact that, as long as the irritating cause continued, there was no chance of cure, he was advised to that effect, and told to return for treatment when he could take a long rest. He has only been seen once in many months, and that was a week ago. He was still at work, his hands getting worse.

The absence of any pain in the course of the disease, and the well-known indifference to the future of the African race were elements in the case which it was useless to contend with, especially as it could be easily seen that he was one of the easiest-going, happiest, good-humored darkies in the world, who could even grin while he picked out the bones of his fingers to throw them away.

It is not my purpose to discuss minutely the causes and treatment of such a common trouble. The interest in the case lies chiefly in the amount of destruction of tissue gradually superinduced by external causes, and in the indifference to the surely increasing demolition of his hands which the patient stoically exhibited.

In ordinary cases of callosity without ulceration, pain does not enter into the consideration of the disease, as it is seldom present; but its absence with ulceration and abscesses is rare, even in the negro.

The consideration of this point, and to call attention to another source of error which leads many physicians to refer every skin disease to syphilis, is my excuse for presenting this short paper.

November 1, 1885.—Since reading the history of the above case in August last, the patient has presented himself again at the dispensary (Oct. 23) with the following changes. All the fingers have healed. There are no callous spots on either hand. The thumb of the left hand where the bones of the joint were exposed, still has a healthy nail, but is half an inch shorter than formerly. It looks as if it had been telescoped backwards, for it has only one remaining joint.

The skin of both hands is healthy-looking, and the left hand, as a whole, appears like a congenital malformation where the fingers have never developed. The man is still at work as a fireman, and his only

treatment has been the wearing of the india-rubber mittens turned wrong side out—the india-rubber coming next the skin—and an ointment of salicylic acid, five per cent, in vaseline. He has taken no rest.

The result obtained by this treatment, although quite unexpected—vide prognosis above—seems to still further justify the opinion that the mechanical injury and the constant exposure to intense heat, which in one sense is traumatic in its effects, were the causes of the trouble.

If it had been neurotic in origin, or a disease of the skin *per se*, the simple protection of the parts would not have resulted so satisfactorily. In a healthy man, any sort of ulceration will speedily tend to recover if non irritated. The surprisingly good result in this case encourages us to believe that by mechanical protection we may, more frequently than is thought, counterbalance mechanical irritation.

SOME OF THE USES OF PYROGALLIC ACID IN DERMATOLOGY, AND THE DANGERS ATTENDING ITS APPLICATION.¹

BY

CHARLES W. ALLEN, M.D.,

Surgeon to Charity Hospital.

ABOUT seven years ago, Jarisch, of Vienna, introduced pyrogalllic acid to the medical profession, especially as a substitute for chrysophanic acid in the treatment of psoriasis, and it has since been used in a variety of skin lesions with much success by many dermatologists. At times its application has been followed by poisonous effects, and for this or other reason, after making a trial of the drug, some have given up its use.

It was the writer's good fortune to pass a year in Vienna just after the introduction of this then new remedy, and to see its use extended by Kaposi and Neumann to the treatment of lupus and epithelioma. Many cases of these diseases as well as of psoriasis were treated at the clinic that year, the ten-per-cent ointment with vaseline, as recommended by Jarisch, being generally used.

As regards the treatment of lupus, we have such high authority as Schwimmer, of Budapest, and Besnier, of Paris, for saying that in pyrogalllic acid we possess one of the most useful means of treatment. Probably no one has had a more extended experience with this acid than has

¹ Abstract of a thesis read before the New York Dermatological Society, Oct. 27, 1885.

Besnier.⁴ He began using it immediately after its introduction into medicine, and has since continued to make extensive use of it. He regarded it three years ago as superior to all other local applications in the treatment of psoriasis.

With reference to its employment in lupus, Besnier says, in the *Annales de Dermatologie et de Syphiligraphie*, January, 1885, that pyrogallic acid produces perfectly the desired action of provoking a suppurative dermatitis. And especially can it be resorted to in those very old cases of lupus, and very extensive ones, which have already been mutilated, and are refractory, in a measure, to all treatment. He advises a saturated solution of the acid in ether, to be brushed over the diseased surfaces, or a spray of the same applied. This he covers at once with a layer of "traumatine." The applications are to be repeated until all lupus points have disappeared from the cicatrix.

He considers this the least painful and the most expeditious plan of treatment that he has found, especially for the varied forms of Willan's lupus.

Schwimmer presents his views on his method of treatment in the *Wiener Med. Wochenschrift*, XXXIV., 20-22. To prevent the return of tubercles in the cicatrix (which is a common occurrence after the apparent cure of the disease), he employs emplastrum hydrargyri to promote the absorption and complete the cure.

The application is made as follows: Vaseline is first applied for several days, or as long as necessary to remove all secondary morbid products, scales, secretions, and dirt, a ten-per-cent pyrogallic ointment is then applied during from four to seven days, being renewed two or three times daily. Vaseline is now to be applied again for one day to remove all of the acid. The entire suppurating surface is now to be covered with the mercurial plaster, under which healing takes place in from ten days to two weeks. This process may be gone through with several times until no more tubercles appear. Prof. Schwimmer says the treatment of a case seldom exceeds three or four months. A speedier and much better resolution of the most advanced and wide-spreading lesions are found to take place under this combined plan of treatment than could be accomplished by the combined treatment of scarification and the thermo-cautery.

He considers the combined method especially indicated in the most extended forms of lupus, and in the neglected and untreated cases. Relapses may occur as after other plans of procedure, but are least to be expected when the treatment has been thorough.

My own experience with pyrogallic in lupus, although quite limited, has been very favorable. Many of the cases met with are extremely obstinate and rebellious to any treatment, and progress or recur in spite

of well-directed effort. Again many of the methods of treatment are exceedingly painful, and although that by pyrogallic may be made so, and at times is so, notwithstanding our desire to secure the result with the minimum amount of pain, still it must be regarded as a comparatively painless procedure.

In cases where the disease has returned in the cicatrix of a patch previously scraped, burned, or treated in some other way, this method has appeared to me to be of especial value. The acid seeks out, so to speak, the individual tubercles or nodules of the disease, and determines a destructive ulceration in and about them, leaving the healthy tissues unchanged. I have seen such a scar appear quite sieve-like or worm-eaten after a few days' application of a pyrogallic ointment, and then heal up nicely and quickly under a zinc-oxide ointment.

Cases I., II., III., and IV. omitted for want of space.

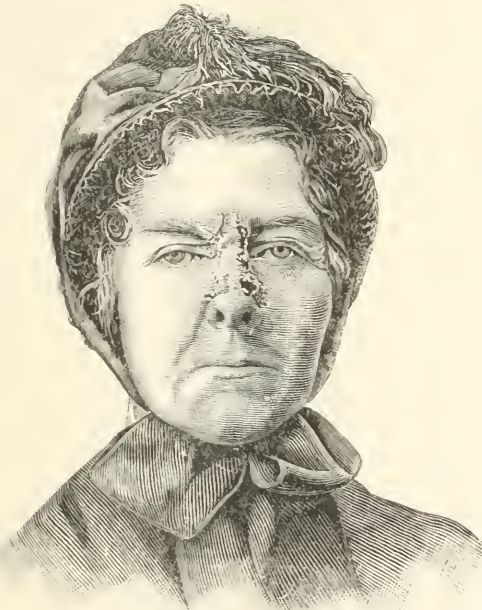
The following case was sent to me by a physician for treatment just one year ago.

CASE V.—Mrs. D., Newburgh, N. Y., æt. 64, presented herself at my office on May 31, 1884, with an extensive lupus vulgaris of the nose, which she says began nine years ago, on the bridge of the nose, where the eye-glasses made pressure. Her family history indicates marked tendency to scrofulous affections. The previous history is that, after measles, she was much troubled, for a long time, with an affection of the eyes and ears, and had glandular enlargements in the neck, which became ulcerated, and have left characteristic scars. While young, patient always had acne, and during her whole life has had more or less eczema of the ears. I may mention as having a bearing on the case that the lady's daughter has been treated by me for acne and a generalized psoriasis.

When I first saw the case, the disease extended from above the eyebrows down over the nose to within about half an inch of its tip, extending on either side almost to the inner canthus of the eyes, and spreading out slightly upon the cheeks. The ulcerated surface, which was covered with a thick, dirty crust, formed a triangle, inclosing a cicatrix which was thin and tensely stretched over the bridge of the nose. The patient states that the disease has gradually extended, notwithstanding a great variety of applications, caustics, blood-purifiers, teas, Indian remedies, quack preparations, and the treatment, from time to time, of regular physicians. The nose has never been entirely healed since it first became ulcerated, and having given up all hope of its ever being cured, she has had no treatment recently.

The tubercular infiltration, consisting of soft subcutaneous, reddish-brown papules, having, however, encroached upon the eyes, and already invaded the upper lids, she now again seeks relief. She objects strenuously to any operation or painful application, and says she will be satisfied if the progress of the disease in the direction of the eyes can be arrested, no matter how long a time is required. I did not promise to accomplish this result, if restricted in the choice of method, but decided that pyrogallic offered the best means in such a case. After applying vaseline to remove all crusts and prepare the ulceration, I began dusting powdered pyrogallic

acid upon the right side of the nose on June 14, and continued it daily, or every second or third day. In the mean time, an ointment of equal parts of emplastr. hydrargyri and ung. diachyli was kept constantly applied to the left side. By June 28, the right side had greatly improved, but the left had remained in *statu quo*. The powder was now applied to the lower third of the ulceration on the left side. A ten-per-cent ointment was employed in the intervals between the applications of the powder during a portion of this time. On August 18, some new lupus nodules, which were encroaching on the canthus on either side, were scraped out, and the acid was now applied to the whole surface. The accompanying cut, from a photograph taken at this time, shows the condi-



SCHWITZER

tion, a portion of the right side being healed. This treatment was, in the main, followed out. She was given, at different times, iodine, iron and malt extract, but never continued any internal remedy long enough to affect the disease to any great extent. In the latter part of November, I stopped applying the powder to the slight ulceration which remained, and used, for eight days, a thirty-grain-to-the-ounce ointment, followed by emplastr. hydrarg. for two weeks, as recommended by Schwimmer. I found this to hasten the curative process materially. On December 10, the nose was to all intents well. The cicatrix was pliable, without any sign of tubercle remaining or forming in it. On December 16, patient returned to her home, much gratified at the result, and, so far as I know, has continued well.

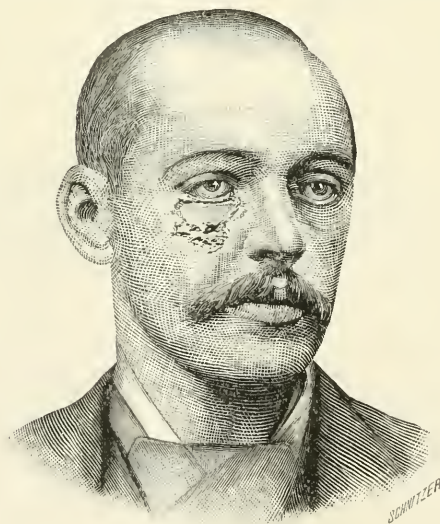
Whenever lupus tubercles are not encountered, the action of pyro-

gallic acid is, as a rule, quite superficial. Besnier says that lupus erythematosus is less benefited than the other form unless it is of a very superficial variety. I will relate the following case of lupus erythematosus treated by the acid :

CASE VI.—Mrs. A., of South Carolina, came to consult me, on August 27, 1884, in regard to a red spot on the end of the nose, which had begun four years before as a small pimple, and had increased slowly in size, occasionally becoming somewhat scaly. It measured about one centimetre in diameter. The centre was covered with an adherent crust, where a slight ulceration had recently taken place. I removed the crust and applied powdered pyrogallic acid, and furnished her with the powder to continue the treatment, when she was about returning to her home. On November 13, she wrote me that the disease was spreading, and rather worse. I now ordered a five-per-cent ointment, to be followed by mercurial plaster (Schwimmer's method). At Christmas time, she sent word that the spot had entirely healed, and that the disease was, to all appearances, cured.

I have at the present time two cases of lupus vulgaris under treatment.

CASE VII.—James C., Ireland, age 30, presented himself on August 19, 1884. He had upon the right cheek a patch of lupus, extending



from the margin of the lower eyelid down upon the cheek. The lower half of the patch, measuring about one and a half inches in either diameter, was ulcerated and elevated above the surrounding skin, standing out an eighth of an inch or more from the surface. The tissue composing this mass was yellowish in color, and although of firm consistence, easily

breaking down; it continually discharged a yellow-colored fluid. A deep sulcus occupied the whole length of the lower lid, just beneath the line of the lashes, all of which had been destroyed. At the inner canthus the disease had extended upon the mucous surface of the lid. This condition had produced a marked ectropion, and the eye was kept constantly irritated. The disease first began as a papule under the skin of the cheek, nine years ago, and gradually extended.

For five years patient states he was under continuous treatment, without the process being entirely arrested. For some time before he came under my observation, the disease had been neglected. I removed the tissues which projected above the surface with the knife, and after removing all crusts, applied powdered pyrogallie acid to the whole surface, and repeated the application almost daily. By September 1, the sulcus of the lid had healed almost to the inner canthus, and by September 20, the entire patch was healed, excepting a small ulcerated surface at the inner canthus of the eye, where the disease still extended upon the conjunctival surface. Finally, this, too, healed perfectly under the powder, and the patient stated that the face had never been so well since it first became ulcerated.

As I had anticipated, the cicatrix became nodular after a time, and the disease began to show itself at several points. I now scraped out all the nodules which would break down under the sharp spoon, and reapplied the powder, renewing it as often as the crusts, which formed after its use, could be removed without violence. Again a fairly good cicatrix was formed, but I now took the precaution to order mercurial plaster to be constantly applied. After being absent, and without due care for some time, patient applied again for treatment, about the first of May. At the lower edge of the cicatrix there were two small circular ulcers, having elevated firm edges, with some papules or nodules in their neighborhood. At the external canthus of the eye, this time, we find an ulceration, and as the lid is everted, a whitish wart-like mass is seen projecting inward from it, similar to that which existed on the cheek when first seen. Another infiltrated mass, slightly ulcerated, and also extending well upon the inner surface of the lid, existed at about its central part. These ulcers of the lid have since been treated with the powder. The larger ulcerations were treated for a week with ointment, in the strength of a drachm of pyrogallie to the ounce, followed by emplastrum hydrarg. until May 12, when the powder was substituted, as little improvement had taken place. The pyrogallie ointment was also applied again, and changed two or three times daily until the 17th, when a deep ulceration had occurred. I now covered the lesions with a ten-per-cent solution of pyrogallie in collodium, for five days, when the tissues appeared healthy, and the emplastrum hydrarg. was again ordered.

This has since been kept up. On June 6, a fine cicatrix had been formed, and the infiltration of lupus tissue was so slight at the edge of the lid that the patient considered himself cured.

About the end of July I heard indirectly from this case that it was remaining well.

CASE VIII.—John D., native of Ireland, age 45, came to the University dispensary on March 2. He presented a patch of lupus vulgaris,

high up on the forehead, about three centimetres in diameter. He stated that it had begun before his eighteenth year, and had been without treatment to speak of until last summer, when caustics caused the central portion to slough out. One portion of the patch is now ulcerated and covered with a crust. I applied for four days equal parts of unguentum hydrargyri and adeps, which softened the tissues somewhat and caused slight ulceration at several points. I now applied a ten-per-cent pyrogallic ointment for a week or ten days, and followed it by the mercurial plaster for two weeks. This process has been repeated several times, and when last seen, after about two months' treatment, the ulcerated surface which had been produced was granulating, and gave reason to anticipate a good result.

As Schwimmer says, it is probable that in lupus the total destruction of the infiltration is rarely possible by the agency of pyrogallic acid alone. It does in some instances destroy the infiltrated cells and lupus nodules in a remarkably short time, and the resulting cicatrix may appear quite free from the morbid growth; but, sooner or later, new points of disease are apt to appear either in the cicatrix or at its margin.

This limit to the beneficial action of pyrogallic is not true of lupus alone, but appears to be a general characteristic of its action. Vidal found that up to a certain point only did the acid exercise a beneficial action on chaneroids, and he advised completing the cure with iodoform.

Vidal was the first to make use of the drug in soft chancre, and after an extended trial of its merits, reported such success with it that he was followed by Terillon, who applied it to all cases of ulcerating chaneroids coming into his service at the Lourcine Hospital during a period of three months. At the same time, Mauriac was experimenting with the drug at l'Hôpital du Midi, and obtaining very favorable results. The mode of application was chiefly in form of ointment, but Vidal also recommended a powder with starch, one to four. The pain caused by these applications amounts to nothing as compared with that caused by the various applications so much in vogue in chaneroid. I find the pain caused by the pure acid is only momentary and not severe in these cases, and I prefer to dust the sore thoroughly the first day with the pure powder. The following day, after removing any crusts, I apply a collodion dressing containing ten per cent of pyrogallic.

After a few days, a healthy action will be established, and iodoform, black-wash, or other dressing will be sufficient for the after-treatment.

Ointments are always uncleanly, and to me unsatisfactory dressings for venereal sores. A well-made fixed dressing which will adhere to the parts is much to be preferred.

Pyrogallic acid, I believe, will be found useful in a variety of skin lesions to which it has as yet not been extensively applied. In the following case, I obtained a good result with it after all other means employed had failed.

CASE IX.—Miss C. came to me on Feb. 1, 1884, suffering from tylosis of the feet and a fungous, or more properly, a villous growth, having a diameter of about two and one-half centimetres in the centre of the right heel, which had resulted in some way from the thickened epidermis of the sole, and had existed for over a year. It had given her great annoyance, preventing walking except with much pain, and had obstinately persisted in spite of all remedies. A sulcus running down into the corium encircled the base of the growth. The patient refusing to permit me to scrape out the diseased tissue, I consented to try other means. For six months I made every effort to effect a cure. I removed the masses of thickened epidermis surrounding it, and applied in turn nitric acid, carbolic, nitrate of silver, ointments of red precipitate, of salicylic, diachylon, and a variety of others. I applied various fixed dressings, medicated collodions, etc., but all to no purpose. Improvement only took place for a brief period. I now applied pyrogallic in liquid gutta-percha, a drachm to the ounce. Within a month, great improvement had taken place, and by January 19, it was apparently cured. In March, however, the heel swelled up, became tender, suppurated, and left an ulcerated surface. The traumaticine and pyrogallic acid were again applied, under which healing took place by April 18, since which date it has remained perfectly well.

The dangers attending the use of this agent which we have been considering are twofold. That is to say, they not only have reference to the constitutional poisonous effects at times observed, but also to the local injuries occasionally met with. So far as I am aware, no severe cases of poisoning from the external application of the drug have been reported in this country, nor have I seen any account of its injurious effects upon the tissues locally. I desire more especially to call attention to the harm it is capable of doing to the healthy skin, but as the subject has not received much attention in our country, I may be pardoned if I run over the cases in which poisonous symptoms and even fatal results have followed its use.

All who employ the comparatively new remedy should keep in mind these possibilities so as to guard against the occurrence of poisoning, and by recognizing the earliest symptoms be able to apply at once the proper remedies.

Just after its introduction into dermatology, Neisser published, in the *Zeitschrift für Klinische Medizin*, an account of a fatal case of poisoning by the drug following a single application of a ten-per-cent ointment. The patient was a strong, healthy man, aged 34, who came to the clinic at Breslau to be treated for psoriasis. On the night of his admission, after a vigorous friction with the ointment, which caused some burning, he was attacked with shivering, had three or four diarrhoeal stools, and vomiting of a glairy mucus. The next day the same symptoms continued. The skin assumed a greenish-brown hue. There was a continuous tremor of the lower jaw. The following day the patient was in a

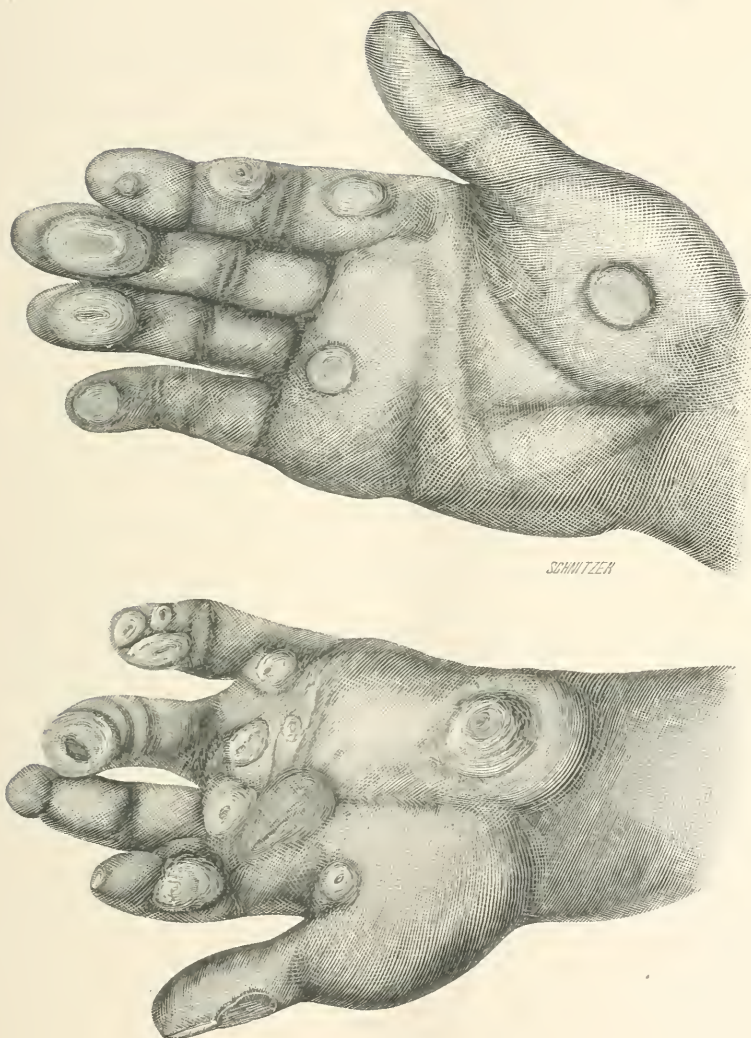
state of collapse, and on the morning of the fifth day he died in coma, after a train of symptoms to which we will again refer.

The urine passed during the last two days showed the most marked form of hæmoglobinuria. The color was dark-brown, with a greenish tinge to the topmost layers. Its reaction was acid. Specific gravity 1.014, and the spectroscope showed the characteristic lines of hæmoglobin. At about this same time (1878), Vidal had the misfortune to lose a patient 18 years of age, who was under his care at the St. Louis. He was being treated for a psoriasis of two years' standing, with a one-to-ten pyrogallie ointment, which the patient applied himself to the whole body. About the fifteenth day, after using more than he had been instructed to do, vomiting and diarrhoea suddenly came on, hæmaturia and anasarca, attended with dyspnœa, rapidly developed, and death ended the scene some fifteen days later.

Up to this time, Besnier had repeatedly applied ointments containing as much as twenty-five per cent of the acid to the whole body. Now, however, warned of its dangers, he reduced the percentage to ten, and even five, and began to watch his cases more closely. Three years passed, and no evil results other than an occasional erythemato-vesicular eruption followed the use of the drug. Suddenly a patient who had entered the St. Louis with a generalized psoriasis of seven years' standing showed symptoms of poisoning after three frictions with the five-per-cent ointment. This patient was also a strong, vigorous man, still his symptoms were so profound that on the fourth day he was apparently dying. It was only after the most vigorous treatment with sinapisms to the whole surface, hypodermic injections of ether, inhalations of oxygen, and the administration of alcohol, all many times repeated, that his life was saved.

The following case was reported by Besnier, to whom it had been communicated by Pick, of Prague. On January 1, 1881, an otherwise healthy servant girl, aged 27, was ordered a ten-per-cent pyrogallie ointment to be applied to a psoriasis. It was rubbed into a different region of the body each day until January 7, when a marked inflammatory action was noted. The applications were renewed, however, on the succeeding day, and towards evening the girl complained of a headache and general malaise, subsequently rigors, vomiting, and temperature rising to 40° C. were noted. After a night of great restlessness and excitement with burning thirst, the urine having a sp. gr. of 1.030, was found bloody, containing hyaline casts, and giving the spectra of hæmoglobin. The patient was put into a wet pack, which produced diuresis and abundant diaphoresis.

Albumin remained in the urine for three days. Patient was finally discharged cured.



Dr. Morison's case of Tylosis (Callositas).

Reviewing these cases, which, so far as I am aware, are all that have been reported, although presumably not the only ones which have occurred, what have we to learn from them?

The facts furnish proof that the drug is at times dangerous, and may be even fatal, and that the poisonous effects can be produced by absorption through the skin. They would also appear to show that an idiosyncrasy or personal predisposition must exist for the drug, as only here and there one is affected from the same strength of application, and in one case a fatal result followed a single application. Still, on the other hand, the tardy poisonous effects, only showing themselves after the use of the ointment for a considerable time, is not what we should expect where this idiosyncrasy exists.

The weak and sickly do not appear to be so easily affected as the strong and robust. In every case mentioned, we are impressed with the fact that the subject was a vigorous, healthy individual. We learn also from these cases that it is not safe to practise frictions over too extended a surface at a time, and that a mild ointment should be used, especially in new cases. Besnier says that not over five grams should be used in the twenty-four hours. The effects caused by its absorption are probably due to the great affinity of the drug for oxygen, or as the pyrogallie oxidizes into carbon monoxide, carbon dioxide, acetic acid, and probably other substances, these same reactions may take place within the economy, in the presence of the alkaline blood, and the toxic effects be due in a measure to them, as well as to the abstraction of oxygen, and it is indeed to the removal of oxygen from the blood that many of the symptoms may be referred. Personne says that the effects produced are the same as in poisoning by phosphorus, and it is, in a measure at least, due to its deoxidizing properties that the injurious effects of phosphorus are due.

The principal symptoms found in these cases are: chill, rigors, or shivering, preceded possibly by malaise and headache, and coming on rather suddenly, at a variable time from the beginning of the applications. There are usually diarrhoeal stools and vomiting of glairy mucus. The patient soon sinks into a state of collapse with sunken eyes, pallid or cyanosed appearance of the lips, a peculiar greenish hue of the skin, elevation of the pulse-beat and temperature, and acceleration of respiration with dyspnoea. The urine becomes dark-brown or black, of high specific gravity, and usually contains hæmoglobin and albumin. The reflexes are diminished. In the early stages there is marked insomnia and restlessness. Toward the close there may be coma. The dyspnoea is due to pulmonary œlema and congestion of the lungs. There may be a condition of general anasarca.

The symptoms persist only so long as the poison is being eliminated,

and when this has been accomplished, convalescence is good and rapid, provided the patient's strength be maintained. In these four cases we find two deaths and two recoveries.

As to treatment; that adopted by Besnier, in the case in which the patient's life was saved after being despaired of, appears rational. He was led to make use of the oxygen inhalations by the brilliant results obtained from it in the intoxication from carbon dioxide, in true asphyxia, and in malignant syphilis. He looks upon the vomiting and diarrhœa as salutary, and does not advise their being checked.

I desire now to call attention to the injurious effects at times produced by pyrogallic acid on the tissues to which it is applied. So far as I have been able to learn, no one has pointed out the dangers to which the healthy skin is subjected, further than to mention that a dermatitis or erythema may at times be produced. Authors state that the healthy skin is not affected; that in lupus, for example, the acids acts only on the lupoid tissue, destroying the nodules of the disease, leaving the adjacent skin uninjured. Now this is true to a very great extent, but I have been made disagreeably aware of the fact that the action of the drug does at times overstep the bounds of the disease, and cause serious injury to healthy parts.

I will illustrate with two cases which have recently been observed by me.

CASE X.—Lucy G., æt. 12, presented herself on November 10, 1884, for the treatment of psoriasis, which occupied the parietal region of the scalp on either side, and an area on the right thigh, the size of the palm. A ten-per-cent pyrogallic ointment was ordered. During the first week there was marked improvement. Upon her third visit about a week later, the tissues for an inch beyond the edge of the plaque and the diseased area itself were blackened and charred, and the skin of the thigh much inflamed for some distance about. She had suffered much pain, and walked with difficulty. The ointment was discontinued, the thigh cleaned of any ointment remaining upon it, and a zinc-oxide ointment substituted. There developed an ulceration of the healthy skin about the patch which did not heal until some time in December. By February 1, when she was last seen, the skin had almost regained a normal condition, but was still of a dark-red hue and somewhat pigmented.

CASE XI.—Jas. G., æt. 28, presented himself on November 24, 1884, with psoriasis affecting the hairy scalp and forehead. There existed also on the right leg a patch of the disease about two and a half inches in diameter. I prescribed an ointment of naphthol for the scalp, and a ten-per-cent pyrogallic ointment in vaseline for the leg. This was applied for about a week, when the patch became black and hardened, and the skin for about an inch beyond blistered, and presented the appearance of a burn. Soothing applications (simple cerate or vaseline) were applied. By January 3, the charred tissues had sloughed off, leaving an ulcerated surface twice the size of the original psoriatic patch. This, in healing, left a disfiguring cicatrix, with bands radiating from

the centre to the periphery, resembling the spokes of a wheel. The patient expressed himself as being entirely satisfied with the result, since the diseased patch had been destroyed. To me, however, it was not at all satisfactory, and I could only congratulate myself that the scar was not upon a more exposed region of the body.

I could find no satisfactory explanation for the violent action of the ointment in these cases. I was using almost daily the same strength in vaseline and simple cerate, put up by the same druggist, without noticing any other bad results. I have, however, in several instances of lupus and epithelioma, seen strong applications destroy an area of cicatricial tissue which was apparently free from nodules or infiltration of the disease.

As a rule, no ill result is to be anticipated from the application of the drug to the healthy tissues, and so little effect does it usually have, that I have applied the powder to the conjunctiva a number of times without producing more than a transient burning sensation.

Occasionally, after using pyrogallie acid for some time, much pain is complained of, and the tissues become inflamed. It is always well in this event to cease its application for a time and substitute some bland ointment.

In preparing any application of pyrogallie acid, care should be exercised to avoid any combination with an alkali, which would neutralize it, and any combination with a metal which it would reduce. Vaseline, being neutral and not subject to any reactions with pyrogallie acid, has appeared to furnish an excipient free from all objections. Its penetrating power is, however, not great, and on this account an animal fat is at times preferable. Owing to the de-oxidizing power of the acid, these fats readily decompose and produce irritating bodies, and indeed it is due to this fact that an irritation of the healthy skin takes place at times, after continued applications. When, therefore, animal fats are made use of, the ointment should be prepared only in small quantities and only used while fresh.

Aside from the use of the powdered drug in full strength, and of the five and ten-per-cent ointment, I have employed at times the various combinations of pyrogallie acid with gelatin, collodion, and gutta-percha, which of late years have been recommended, and which are now prepared and placed upon the market by a number of firms. In many cases they are greatly to be preferred to other applications, having the advantage over them of cleanliness, ease of application, a certain amount of pressure exercised and support given to the tissues, etc. The application of the powdered pyrogallie acid causes, occasionally, thick crusts to form, which may become irritating to the tissues and which at times are not easily removed.

I have had successful results in psoriasis and other affections, from the employment of a collodion containing about forty grains of pyrogallie acid to the ounce, and the addition of eight or ten drops of castor oil.

This forms an excellent dressing for lesions about the face and other exposed parts. When first applied to a raw surface, some pain is experienced, but this soon passes away. It had seemed to me that from these fixed dressings only a slight effect of the drug could be obtained, but I have been surprised at times to see how marked an effect is produced by them.

To procure, however, a powerful and speedy result, it has appeared to me well at all times to apply the powder to the lesions, and after drying of all secretions, to paint over a medicated collodion or traumaticine.

In conclusion, then, we find that in pyrogallie acid we have a drug valuable, not only in psoriasis, for the treatment of which affection it was first introduced, but furnishing one of the means of combating other and more serious diseases.

That its application is not without dangers both to the general system and to the body's healthy surface. That it is capable of producing death in the one case, and extensive sloughing in the other. That although the application of the drug in its full strength as a powder is efficacious, it is attended with some disadvantages. The crystals should be powdered before being applied.

For many cases a well-made fixed dressing, which adheres nicely to the part, possesses advantages which make it preferable to other applications. This is especially true of lesions of the face and hands.

The intensity of the effect produced appears to be in a measure proportionate to the thickness of the layer of fixed dressing painted upon the parts.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

158TH REGULAR MEETING, NOVEMBER 24, 1885.

DR. W. T. ALEXANDER, *President, in the Chair.*

DR. ROBINSON presented a

CASE OF LICHEN PLANUS.

John S., 30 years. First noticed eruption on scrotum fifteen years ago, and has never been free from it in that situation since. He did not notice the lesion elsewhere until three or four months ago. Now the entire scrotum is covered with

a number of papules ; some of them are isolated, others have coalesced, forming large patches. On the left side of the penis are a number of papules, forming a ringed appearance, resembling somewhat a *tinea circinata* ; in this situation, the lesion appears to spread peripherically, and heal more or less in the centre. On the right ankle are several papules, some isolated and discrete, while others have coalesced. There are also some papules in the right popliteal space. These papules are flat and shiny, and present all the appearances of lichen planus, the peculiar feature in the case being the coalescence in many places of the papules. The eruption itches greatly in damp and cold weather : this is relieved by the application of very hot water. The patient has always enjoyed good health, with the exception of occasional attacks of rheumatism.

DR. MORROW said that the case was a very interesting one in the mode of its distribution, and also in the apparently stationary character of the lesions. He had watched many cases, but had never seen one in which it took more than three or four months for the complete evolution of a papule. He had serious doubts as to whether any individual papules remained fifteen years ; if so, it was quite remarkable. He thought that the crescents and segments were formed by the coalescence of separate papules, and not by peripheral extension, with healing in the centre of individual papules.

DR. TAYLOR had seen instances where these segments and circles resulted from the coalescence of the papules, but he had never seen them formed by the clearing up of patches in the centre and their extension peripherically.

DR. FOX said that he had made a careful study of the different varieties of lichen planus, and had called attention to three distinct forms of the disease. In the first form the papules have a depressed centre with an angular outline, and appear generally on the arms and forearms ; this is the form described by Wilson, he (Dr. Fox) spoke of it as the lenticular in contradistinction to the miliary, and a third variety caused by the fusing or coalescence of miliary papules producing the annular form. In the latter variety he believed that the patches increase in size by the growth of new papules. He thought that fifteen years was a long time for a papule to remain, and believed that new ones were constantly being formed. He had seen cases benefited by the application of a strong solution of pure carbolic acid which stopped the itching. He had also used Unna's ointment containing a strong solution of bichloride of mercury.

DR. SHERWELL said that most of his cases had occurred in persons broken down in health. He generally gave tonics, and mainly arsenic, to build them up. Some of the lesions would disappear without treatment. Locally he used a lotion of bichloride of mercury, dilute hydrocyanic acid, and emulsion of bitter almonds to allay the irritation.

DR. JACKSON mentioned two cases which he had treated with Unna's ointment with remarkable success.

DR. KEYES remembered a gouty family where two members had lichen planus in the same year, which disappeared under treatment, to return again on the hands the following year, it again disappeared and did not return again. In these cases the treatment was mainly alkaline.

DR. TAYLOR, when at Bellevue Hospital, had obtained good results from the use of the following ointment : \mathcal{R} Olei rusci, vel Olei cadini, 3 i.; Ungt. hydrarg., 3 ij., Ungt. simplicis, \mathfrak{z} i.; M. ft. ungt.

DR. MORROW had two cases under observation several years ago: one was a woman who had rheumatism ; he gave alkaline diuretics, and used sedative lotions ; she recovered in a few months. The next case got well in about the same time without treatment, so he concluded that in some cases, at least, the lesions disappeared spontaneously.

DR. BRONSON wished to say a few words in reference to treatment and especially the use of carbolic acid ; he had employed it in solution in the proportion of two drachms to the ounce. Internally he used various remedies, more particularly mercurials, and he recalled one case where the lesions had remained for a long time, Donovan's solution was given with the effect of causing the eruption to disappear in a very short time, but he had never again had a similar case. He had had many cases in which the lesions disappeared spontaneously.

DR. FOX said that he had obtained the best results by touching each individual lesion with pure carbolic acid; latterly, however, he had been using the bichloride of mercury in ointment. He mentioned a case under his care in the hospital, in whom the surface from head to foot was covered with an eruption like an infiltrated or dry eczema, with here and there a few typical patches of lichen planus. In this case a very weak solution of carbolic acid caused a severe dermatitis of the hands and feet.

DR. SHERWELL suggested the use of a lotion containing thirty to forty grains of nitrate of silver to the ounce, with spiritus ætheris nitrosus, one part in four. He believed that it would allay the itching.

DR. ROBINSON said that he differed from Dr. Taylor in regard to the mode of the extension of the lesions. They frequently begin as small spots and become as large as peas, sinking in the centre. The centres will clear up to a certain extent, presenting a violaceous surface. He has watched individual patches getting larger by spreading peripherically. They may commence as small as a pin's point. He believed that the patch on the penis had become larger by peripheral increase and not by coalescence of a number of papules.

DR. TAYLOR conceded what Dr. Robinson said in reference to the peripheral extension of patches of lichen planus, and he found that the patches clear up in the centre, becoming violaceous; still the skin was not healthy as in psoriasis; in other words, where the clearing up process has taken place, there is a hyperæmic condition left.

DR. ROBINSON said there was another form of lichen planus, resembling a dermatitis or follicular eczema, but differing in the length of time that an individual lesion remains. He usually gave tonics, especially strychnia; this patient was taking iodide of potassium without much benefit, and he soon intended to give tonics.

DR. KEYES shewed a peculiar

CASE OF ACQUIRED SYPHILIS.

X., aged 19, was presented to the Society a year ago. At that time his history was that he had been perfectly well until the age of 7, when, as he says, he had rheumatism and fever. When 16 years old he went to Mt. Sinai Hospital with a swollen testicle, which had been gradually growing larger for several months. The malady was called orchitis, and treated by strapping with rubber; great pain resulted, and finally his testicle was removed with the knife. He remained well until August, 1884, when two lumps appeared on his face, one on the forehead first, then another on the left malar bone, they grew slowly without pain. He was first seen by Dr. Keyes in the autumn of 1884, who concluded that the swellings from their physical characters must be gummata, and treated him accordingly by mixed treatment, with rapidly increasing doses of the iodides. He was then presented to the Society. His treatment has cured the tumor on the malar bone, a depression marking the site of the absorption of bone, although there never was any breakage of skin, or escape of a piece of dead bone. The lump on the forehead was too far advanced to allow a cure by medicine. The gumma softened, and the ulcer disclosed bare bone. Dr. Keyes removed a flat scale of the outer table some weeks ago; a portion of the dead bone still remains in the bottom of the ulcer. The other testicle is now enlarged as was its fellow before removal. The patient is still increasing his dose of iodide, which he took badly at first; he has only reached a drachm and a half daily, but is doing well in all respects. His father and mother are strong and healthy. They were married twenty-one years ago, and have seven children; the patient, and six other healthy ones which were born after he was, all are living and free from disease. There is no specific history in the family or in the patient except as mentioned. His teeth are good, and he has no evidence about him of inherited disease, although there is a slight scar in the corner of the mouth. There is no evidence to

show that the patient acquired his malady personally, and the whole question of the origin of the disease is involved in obscurity.

Dr. Keyes presented the case as a curious one, because of the inability to ascertain how the poison entered the system. He believed that it was an accidentally acquired syphilis.

Dr. BRONSON did not consider it a case of inherited syphilis; he thought if it were, it would of necessity have affected the development of the body, the teeth would also be affected, as well as the shape of the head.

Dr. MORROW also thought that the clinical appearances suggested acquired rather than inherited syphilis. He asked Dr. Keyes if he expected to get the same results from specific treatment in a case of late hereditary syphilis, as in the acquired form. He thought that most late hereditary syphilitic lesions were rebellious to specific treatment, and that tonics were preferable.

Dr. KEYES, in reply, said that when a hereditary lesion made its appearance early and remained persistent, lasting even beyond puberty, it was difficult to treat. He did not think that a tardily developed hereditary syphilis was more difficult to treat than an acquired, provided that a number of healthy years intervened before the appearance of the lesions. He mentioned instances where patients were unable to take their medicine when in the city, but if sent to the country their systems were toned up, and they could take the mixed treatment with the greatest benefit, because the hygienic surroundings were better.



DR. PIFFARD showed a

COMEDO EXTRACTOR.

It was made after the pattern designed by Unna, but differing from it in having a convex surface instead of a flat one at each end, and in having the apertures cut to gauge and the openings in convex surface slightly countersunk; the shank was also thicker.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

LEPROSY IN NORWAY—TREATMENT OF PSORIASIS BY CHRYSOPHANIC ACID AND BY THE VARIOUS MEDICATED PLASTERS—INQUIRIES INTO THE TOXIC PROPERTIES OF NAPHTHOL, AS BEARING UPON THE TREATMENT OF SCABIES BY THAT SUBSTANCE—INSTRUCTIONS RESPECTING CONTAGIOUS MALADIES OF THE HAIRY SCALP—TREATMENT OF SIMPLE CHANCER OR CHANCROID—ON THE EXPRESSION OF JUICE, AS A MEANS OF DIAGNOSTIC DIFFERENTIATION BETWEEN SYPHILITIC CHANCER AND HERPES.

Leprosy.—Professor H. Leloir has published in several journals (*Vide Semaine Médicale*, June 24, 1885) a summary of his observations upon leprosy in Norway, during a recent visit to that country. I will pass over his description of the three forms of the disease—the tubercular, the anesthetic, and the mixed—since the synthetic clinical pictures which it embodies would have to be quoted in their entirety, and they correspond, on the whole, to what the standard authors have already taught us. I wish to dwell on those passages only in which the question of

the contagiousness of leprosy is considered. In August, 1884, when the first reliable statistics were collected, the total number of lepers in Norway was about 1,500; nearly 900 of these must have been at large. Besides the 550 in the lazarettos, there were some 50 lepers in the general hospitals, on the same footing with the other patients, and able to leave whenever they wished. Isolation, therefore, in the case of the Norwegian victims, is far from being universally enforced, despite the institution of the lazarettos in 1856 and 1860, and yet their number has gone on diminishing at a remarkable rate since those dates. According to Dr. Kaurin, there were in Norway, in 1856, 2,827 lepers; in 1858, 2,802; in 1859, 2,823; in 1860, 2,785; in 1870, 2,538; in 1876, 2,035; in 1879, 1,774; in 1880, 1,656; lastly, in 1881, from 1,500 to 1,600. Hence, Dr. Leloir is led to propound the question, whether this happy result is really attributable to the establishment of lazarettos. He inclines to think that it is not, but that the leprous families die out after a few generations, owing to the direct effects of the disease, to celibacy, or to their isolation. To these causes, he thinks, may perhaps be added the emigration of Norwegian lepers to the United States. He believes that leprosy is only contagious in a very slight degree, if at all—indeed, it is easy to perceive, from the tone of his article, that he is almost convinced of its non-contagiousness. He refers to cases in which lepers have cohabited with their wives during a lengthened period without affecting them, and in which the said wives have even given birth to perfectly healthy children. He cites the experience of a certain physician who, after several unsuccessful attempts to inoculate himself with tuberculous leprosy, met with the same failure in his experiments upon twenty healthy individuals. I do not wish, on the present occasion, to discuss these opinions of my excellent friend Professor Leloir. You, in America, are in a much better position to do so, since the question of the contagiousness of leprosy is the order of the day in the United States. I will merely remark that the history of leprosy in the Sandwich Islands affords evidence in favor of its contagiousness whose force it will be difficult to overcome.

Chrysophanic Acid in the Treatment of Psoriasis.—Dr. Derobert, in a recent thesis, sets forth the advantages to be obtained from the use of chrysophanic acid in the treatment of psoriasis. The observations on which his essay is based were made in the service of Professor Fournier. In M. Besnier's service the psoriasis-patches are first painted with a ten-per-cent solution of chrysophanic acid in chloroform, which when dry is coated with another protective layer of gutta-percha dissolved in the same vehicle (10 white gutta-percha : 90 chloroform) Professor Fournier, on the other hand, employs but a single solution of gutta-percha and chrysophanic acid in chloroform, and this is only applied once. In this way the clothing is more liable to be soiled than by the former method, but it involves an economy of both time and money which is by no means to be despised in hospital practice. The coating is to be renewed when necessary. By this process most of the cases are cured within periods varying from ten days to a month; sometimes, though rarely, only four frictions are required. I should not have said so much on this subject, if the thesis in question had not contained an expression of opinion which seems to me to go a little too far. I refer to the statement that no danger need be apprehended from general frictions with chrysophanic acid, because this agent is devoid of toxic properties and is not absorbed by the skin. On the contrary, I am convinced that it ought to be employed with the utmost caution, and should never be rubbed in upon the general surface without a previous testing of the patient's susceptibility by partial applications. I well remember having seen, in the year 1880, a man dying at the St. Louis

Hospital, with the most intense general erythema, accompanied by symptoms of severe poisoning, in consequence of a too powerful application of chrysophanic acid. Quite recently I had an opportunity of observing, in the service of Dr. Vidal, a case of general exfoliative dermatitis of two months' duration, with intense fever, which had been brought on in the same way. Such facts as these, even though of rare occurrence, ought, it seems to me, to have made M. Derobert a little more careful.

Ichthyol in the Treatment of Scabies.—Several years have passed since Kaposi extolled the virtues of naphthol β as a remedy for various cutaneous affections, and particularly for scabies. This process is unquestionably advantageous when we do not wish to subject our patients to the treatment in vogue at the St. Louis Hospital, and which is known as *La Frotte*—a treatment whose efficacy is undeniable, since it effects a radical cure within an hour and a half, but which is painful, troublesome, and difficult of thorough application. Unhappily, Neisser, in 1881, proclaimed that naphthol β was far from being an inoffensive substance, that he had observed complaints of the kidneys in children as results of its employment, and that animals on whom he had experimented with subcutaneous injections of an oily solution of naphthol, had died with symptoms of hæmoglobinuria. These experiments have been repeated by MM. Josias and Nocard (*Vide Annales de Dermatologie et de Syphiligraphie*, May, 1885). They have shown that cobayes weighing 400 to 500 grammes can be killed by injecting subcutaneously 15 to 30 centigrammes of a 1-to-10 alcoholic solution of naphthol, and that an injection of one gramme of the same is fatal even to a rabbit weighing 2,500 grammes; but that in large-sized animals naphthol β is incapable of giving rise to any serious symptoms whatever; their conclusion is that naphthol β , in ordinary medicinal doses, is an excellent remedy against scabies, and entirely harmless.

Contagious Diseases of the Scalp in Children.—The senior physician to the St. Louis Hospital, Dr. Lailler, has published (*Vide Revue D'Hygiène et de Police Sanitaire*, July 20, 1885) a set of directions respecting contagious diseases of the scalp in children, designed for the use of parents, teachers, and the managers of public institutions. It cannot be too highly commended to the attentive perusal of physicians. The following are some of the precautions advised by the distinguished author: no child should be admitted into a school without a medical inspector's certificate that it is free from any contagious disorder. Boys' hair should be kept short; as also that of girls until the age of 7 or 8 years. It should be frequently inspected. The children's heads should be uncovered at all times, as far as possible, even during recreation in the open air. Their caps should be of a washable material. Boys' heads should be washed once a week in winter, oftener in summer; using for the purpose a decoction of Panama wood, followed by a rinsing with pure water, and a thorough drying with towels. These ablutions need not be so frequent in the case of girls, but greater care must be taken in drying their hair. In boarding-schools, each pupil should have his own brush and comb, which should be kept perfectly clean. Every child who has had ringworm, and has been re-admitted into school on a medical certificate, should remain under special surveillance, and be inspected by the doctor once a fortnight during the first quarter.

Speaking of ringworm, I must not forget to mention the recent thesis by Dr. Manuel Venegas y Canizaries—a good summary of the latest ideas concerning this topic, and of the methods at present employed at the St. Louis Hospital in the treatment of pelade, of favus, and of trichophytosis.

Treatment of Chancroid.—M. Maurice Notta has put forth an article in *L'Union Médicale*, July 18, 1885, treating of the different methods which have been employed for the treatment of simple or non-infecting, non-syphilitic chancre—the chancroid of English and American writers. He divides them into two kinds—one in which only a topical and superficial action is sought to be produced upon the chancroid; and another which aims at its complete destruction from the very base, and its transformation into a simple sore. To the first class belong the applications of aromatic wine, tartrates of iron and potash, glycerin, dilute tincture of iodine, decoctions of oak or of Peruvian bark, chlorine-water, resorcine, oxygenated water, tincture of thuja, guaco, perchloride of iron, sulphate of iron, silicate of potassium, chloral; also of absorbent powders, such as those composed of calomel, bismuth, camphor, oxide of zinc, quinine, or ratanhia. All these agents may produce good results, but they are less efficacious than those which constitute the second class. A soft chancre may be destroyed either by excision, which is scarcely ever an advisable procedure, or by cauterization, the means usually adopted. Formerly, the arsenical preparations, Ricord's sulpho-carbolated, Vienna paste, acids more or less diluted, etc., were made use of for this purpose. In France, at present, we employ a solution of nitrate of silver, 1 : 30, bichloride of zinc, in the form of *paté de Canquoin*, or a concentrated solution of iodoform—this last having been brought into favor by MM. Besnier and Lailler in 1867—salicylic acid combined either with wheat flour or with powdered gum (one part of salicylic acid to four parts of excipient); pyrogalllic acid, 1 : 5 (Vidal); finally, the thermo-cautery. Quite recently, M. Aubert, at Lyons, has resorted, with success, to the administration of prolonged hot baths; and I have myself effected cures of phagedenic soft chancres by means of very hot cataplasms repeatedly applied. According to M. Aubert, a temperature of 33 C., if maintained long enough, will suffice to modify the chancrous poison, and transfer the virulent ulcer into a simple sore. M. Notta believes that the most efficacious method hitherto devised consists in the complete and simultaneous cauterization of all the patient's soft chancres by means of the thermo-cautery, followed by an antiseptic dressing. I refrain from further details on this subject, since the management of chancroid is so admirably treated in the last edition of Bumstead and Taylor.

Diagnosis of Chancre and Herpes.—In a recent communication to the *Journal des Connaissances Médicales*, Professor H. Leloir describes a means, which he calls the expresseure of juice, for differentiating an infecting chancre from herpes. It consists as follows: when a syphilitic chancre is squeezed between the fingers, only a small quantity of fluid, if any at all, is brought to the surface, and it is very difficult to make it exude a second time. In herpes, on the other hand, the same process forces out a drop of transparent serum, resembling the discharge from certain eczemas, and this result may be produced several times in succession. The histological structure of the respective lesions will serve to explain this difference, a chancre being a syphiloma, a hard and incompressible neoplasm, while herpes, on the contrary, is characterized by the occurrence of local hyperæmic oedema, with vascular dilatation.

Paris, 1885.

DR. L. BROcq.

Reviews.

ACNE: ITS ETIOLOGY, PATHOLOGY, AND TREATMENT. A PRACTICAL TREATISE BASED ON THE STUDY OF ONE THOUSAND FIVE HUNDRED CASES OF SEBACEOUS DISEASE. By L. DUNCAN BULKLEY, A.M., M.D., Attending Physician to the New York Skin and Cancer Hospital, Etc. New York and London: G. P. Putnam's Sons, New York.

Dr. Bulkley enjoys the distinction of being the most voluminous writer on diseases of the skin in this country, and we observe with pleasure that each succeeding production is an improvement upon its predecessor. From a careful examination of the work before us, we regard it as the most creditable contribution the author has made to the literature of dermatology.

Chapter I. is devoted to the anatomy and physiology of the sebaceous glands. The admirable delineations of Sappey which serve as the basis of description, are supplemented by observations of other distinguished authorities.

In Chapter II. the nosology of acne is considered at some length. The historical details relating to the nomenclature and classification of sebaceous diseases by different writers, while adding but little of practical value to the work, are yet quite appropriate in a monograph which aims at a complete and exhaustive presentation of the subject.

Acne is defined "as a functional or inflammatory disease of the sebaceous glands, exhibiting excessive and abnormal, or deficient secretion of sebum; or the inflammatory elements of congestion, papules, pustules or tubercles, located in and about the sebaceous glands; or any or all of these features combined." It will be seen that the author includes anomalies of secretion of the sebaceous structures as well as glandular and peri-glandular inflammations, thus giving a more comprehensive signification to the term acne than is recognized by modern authorities. From a clinical point of view, it is quite proper to class together functional and inflammatory sebaceous diseases, since both forms often coexist in the same individual. Of more doubtful propriety, however, is the inclusion of acne rosacea, which many modern writers entirely separate from the acne group, since the implication of the sebaceous glands is secondary to the erythema and other vascular changes; moreover, rosacea ordinarily occurs at a different period of life and under the influence of causes which have no etiological relation with the production of other forms of acne.

In discussing the etiology of acne, reference is made to the varied and conflicting opinions of different authorities upon this point. Especial prominence is assigned to the rôle played by the nervous system in the causation of acne. He says "the more the subject is studied in all its bearings, the more does it seem probable that, in the majority of instances, the direct cause of faulty secretion from, and congestive and inflammatory action in and about the sebaceous glands is found in a nerve influence transmitted or reflected from other organs or portions of the body."

Among other general or systemic causes, anæmia and debility, imperfect digestion, constipation, disturbances of circulation, etc., are referred to as standing in close etiological relation with disorders of the sebaceous glands. The in-

fluence of sexual derangements upon the development of acne is considered at some length, and the conclusion arrived at that while in the male subject this causal connection is comparatively rare, in the female it is much more positive and pronounced. A subordinate importance is assigned to the influence of local irritants as a direct exciting cause of acne, while allowing that they often aggravate an existing cause.

The clinical description of the various forms of acne is considered in Chapters V. and VI. with their diagnosis and treatment. Considerable space is devoted to the pathological anatomy of the several varieties. This part of the subject has been worked up with much care, and the text is enriched with a number of original drawings by Dr. George T. Elliot, representing the microscopical appearances. The treatment of acne, while containing nothing notably new or peculiar, has been brought fully up to the latest advances made in this department of dermatological therapeutics.

The book concludes with a chapter on diet and hygiene, and a complete and well selected formulary. We commend this work to both the specialist and the general practitioner as the most admirable exposition of the etiology, pathology, and treatment of acne that has ever been given to the profession.

Selections.

THE SIGNIFICANCE AND DIAGNOSIS OF GONORRHOEA IN THE FEMALE.

At a recent meeting of the Hamburg Medical Society, Dr. Lomer read a paper on gonorrhœa in the female, in which he calls attention to the very important rôle which the disease plays in gynecology.

Sänger has made the statement that one-ninth of all cases coming to the gynecologist for treatment are of gonorrhœal origin. Indeed, he is of the opinion that gonorrhœa with its consequent ills is altogether more dangerous and more pernicious than syphilis. To many this statement will appear an exaggeration, but it must not be forgotten that by spreading to the Fallopian tubes a gonorrhœa may set up a pyo-salpingitis which, by rupture, may cause a fatal peritonitis.

This outcome of a gonorrhœa is indeed rare, but grave diseases of the uterus and its appendages resulting from it are daily met with.

The fact that gonorrhœa so frequently passes unrecognized in women, the author believes to be due to a double cause; the patient herself is often unconscious of the disease; and no pathological process is apparent to point out the diagnosis to the physician. Only in recent cases are we sure of finding an inflammation of the vagina with swelling, injection, and granular thickening of the mucous membrane.

The process in the hidden cases is located in the cervix.

Bumm has pointed out the fact that, in searching for gonococci, the secretion from the cervix must be used, and that the cylinder epithelium of this region offers a better soil for the growth of the gonococci. The author has examined

two hundred women at the University Clinic for Women in Berlin, with the following results:

1. He concludes that the vaginal secretion is unsuitable for the discovery of gonococci.
2. That you must look for them in the secretion from the cervix.
3. That only such cases should be regarded as gonorrhoeal as show diplococci shut within the pus cells.
4. That there are, nevertheless, certain doubts about positively assuming the existence of gonorrhoea based on the discovery of such diplococci, for the reason that their existence in slight cases of vaginitis in children, and the frequent appearance of colonies of diplococci in lying-in women, are facts that not yet sufficiently explained.—*Deutsche Med. Wochenschrift*, No. 43.

PROFESSIONAL DERMATOSES.

By the above term Gibout designated, in a recent lecture at the St. Louis Hospital in Paris (*Gazette des Hôpitaux*), those diseases of the skin met with in persons engaged in certain occupations.

Among the employments commonly giving rise to skin affections may be mentioned that of the grocer, who handles such irritating substances as salt, pepper, acids, etc.: dish-washers, who have the hands and arms continually in fatty water, which is first very hot and then cold: blacksmiths and iron-workers, whose faces, arms, and chests are exposed to the intense heat of the furnace: painters, dyers, distillers, and mortar-mixers, all of whose hands come in contact with irritating substances.

Whether acute or chronic, professional affections have special characteristics by which they may be easily recognized:

1. Contrary to the nature of syphilitic and herpetic diseases, they have no tendency to generalize themselves; being produced by local causes, they are limited to the sphere of action of the cause, and remain local.
2. Differing from herpetic affections, they are not pruriginous.
3. Differing again from herpetic affections, they do not present a unity of lesion, that is to say, at the same point we find a reunion or running together of lesions of various kinds: thus we see plaques of eczema surrounded by papules of lichen and pustules of ecthyma, a mixture of affections of different kinds.
4. Differing from herpetic and syphilitic diseases, they have no duration, tenacity, nor tendency to recur. When the local influences which have produced them are removed, they at times get well of themselves without any treatment. Properly treated, they rarely last over eight days, and once cured, do not return unless the patient is exposed again to the same producing causes.
5. They do not affect the general health.
6. They are neither contagious nor incurable.

In treating these cases, the first thing to accomplish is the removal of the cause; this having been done, emollient dressings are recommended, such as poultices of potato, flour, and local baths of bran or starch-water, etc.

If the affection assume a chronic form, a stimulating treatment may be called for, such as frequent applications of oil of cade, tincture of iodine, or a solution of corrosive sublimate, followed by glycerole of starch, vaseline, or oil of sweet almonds, to render the skin again elastic and pliant. Once cured, the patient should give up his occupation, or resume it with great caution.

LUPUS TREATED WITH COLD.

ALMOST all methods of treating lupus have for their aim the destruction of the diseased tissue.

Prof. Gerhardt, of Berlin, proposes a method which has proven somewhat successful in his hands, and which has for its object the destruction of the bacilli which of late years have so constantly been found in lupus tissue. While believing that the tubercle bacillus is a principal factor in the disease, Prof. Gerhardt argued, from the extremely slow progress of many cases of lupus, and from the fact that, at times, many specimens must be examined before the bacilli are found, that some other element must be present which prevents the bacillus from spreading and multiplying with the same rapidity noticeable in other parts. For example, in lymphatic glands the bacilli are often found in closely packed masses filling up the microscopic field, whereas in a giant cell of lupus scarcely ever more than one bacillus is found.

This the writer explains by the superficial situation of lupus and its constant exposure to a lower temperature, and in fact bases his treatment upon this theory of cold exercising a deterrent influence upon the bacilli, hindering their spread. The patient lies for three hours, twice each day, in such a position that an ice-bag suspended from a hook will cover as nearly as possible the lupus patch without making disagreeable pressure.

Four cases were treated, three for a short, and one for a longer period. The results were such as to render the method worthy of further trial.

The advantages claimed for the ice-bag treatment are that the disease is checked in an equally short, if not a shorter time, than by other methods; that the surrounding tissues are not injured, and that the activity of the tubercle bacilli is checked, if not wholly destroyed.—*Deutsche Medicinische Wochenschrift*, October 8, 1885.

INTRA-MUSCULAR INJECTIONS OF METALLIC MERCURY IN SYPHILIS.

DR. LUTON, of Reims, makes the following propositions touching the question of introducing mercury into the system by the hypodermic method.

1. The muscular tissue absorbs metallic mercury more readily than does the cellular tissue.

2. This absorption is proven: *a*, by the therapeutic effects; *b*, by the possible, but not constant, production of mercurial stomatitis; *c*, by direct examination in experiments on animals.

3. Sulphur, employed as an electuary in doses amounting to at least seventy-five grains per day, is far superior to chlorate of potash as a remedy for stomatitis.

4. The dose of metallic mercury at the outset should be at the most fifteen grains, taking as a rule for a repetition of the dose the time when its equivalent in bichloride of mercury would have been taken. Thus one gram of mercury would give 1.354 gram of bichloride.

5. The advantages of this method are: *a*, efficiency; *b*, avoidance of digestive derangement; *c*, the possibility of separating the injections by intervals which can be calculated.

6. Intra-muscular injections of metallic mercury are only recommended, at the present time, for the severe and inveterate cases of syphilis which have

arrived at the period of transition or are in the tertiary stage.—*Gazette des Hôpitaux*, September 12, 1885.

HAMAMELIS VIRGINICA IN THE TREATMENT OF PROSTATIC DISEASE, AND OF BUCCAL CANCER.

Two cases that have recently come under my care seem to me interesting in connection with the use of hamamelis virginica.

One is a case of enlarged prostate requiring the use of the catheter, in which periodical hæmorrhages have occurred simultaneously from the urinary passages and the rectum, no doubt from a congested condition of the veins of both parts. In this case, washing out the bladder with a solution containing one drachm of tincture of hamamelis, and one-half drachm of carbolic acid, in about twenty-five ounces of warm water, has had an excellent effect in arresting the bleeding, and also in allaying the irritability of the parts. Since the use of the injection, the urine has been passed without the catheter; but that is probably due to relief of congestion by the bleeding. The other means found most useful have been leeches to the perinæum, and saline purgatives.

The other case is one of cancer beginning in a rare seat—the right tonsil, and subsequently involving the tongue. In the diagnosis of this case, I had the assistance of Dr. Hodgkinson, of Manchester. A short time ago, a smart hæmorrhage occurred, and tincture of hamamelis in ordinary medicinal doses was prescribed. The bleeding was arrested; but the medicine was found to have such an excellent effect in preventing the formation of sticky secretion on the ulcerated surface and in adding to the comfort of the patient, that it was adopted as a permanent mode of treatment.

The above are comparatively simple cases, and the effects of treatment can only be palliative; but it seems to me that an account of them, as a contribution to the knowledge of the therapeutics of a new drug, may be of some use.—MACKENZIE, *Brit. Med. Jour.*, Oct. 31, 1885.

UNIQUE MODE OF CONTAGION OF GONORRHOEA.

M. HORAUD communicates the following unique case to the *Société Médicale de Lyon*.

M. C., student of medicine, had four years previously an attack of gonorrhœa which lasted about twelve days, and disappeared leaving no trace. This was the only venereal disease he had ever had. On the 10th of July, he visited a public house of prostitution, and with the view of escaping all risk of contagion, he had a connection *ab ore*, with a woman accustomed to this form of exercise. He immediately washed himself and dried the penis with a clean towel. He states that he had no other contact with the woman. The next day he felt a sensation of warmth in the urethra, and pressed out a whitish drop.

On the 13th of July, Dr. H. examined him and found an abundant purulent discharge, the examination of which demonstrated the existence of globules of pus and numerous gonococci. He was treated with injections, and the discharge disappeared in the course of fifteen days.

The woman was examined and found to have neither buccal inflammation nor urethro-raginitis. How explain the development of gonorrhœa in this case? It could not be a simple inflammation produced by suction, since the discharge contained the gonococcus, which proves that it was a gonorrhœa determined by contagion. The probable explanation is that the urethra of my patient encountered

in the mouth of the woman, gonococci deposited in a recent intercourse *ab ore*.—*Lyon Médical*, Nov. 1. 1885.

HERPES FOLLOWING THE EXTERNAL USE OF BELLADONNA AND ATROPINE.

DR. MACKINTOSH reports, in the *British Medical Journal*, Oct. 17, 1885, a case of a patient suffering from chronic rheumatism, who was ordered belladonna liniment for application to a painful knee-joint. The use of this was followed by an eruption of herpes, with a good deal of swelling over the seat of application of the liniment. Recently he had an attack of iritis in right eye, for which a solution of atropine was used to dilate the pupil. Some of the solution ran over the cheek and was, in a few hours, followed by an herpetic eruption of exactly the same character as had followed the use of the belladonna liniment. The swelling was so great that the eye was completely closed.

Items.

LOTIONS OF SULPHIDE OF POTASSIUM.—Sulphide of potassium is a valuable remedy in various skin affections, but hitherto it could not be conveniently used on account of its disagreeable odor of putrid eggs. A method of dissolving it, and, at the same time rendering it agreeable, is to add a quantity of tincture of benzoin equal to the amount of sulphide employed. Thus a solution composed of 15 grains of sulphide of potassium, 15 minims of tincture of benzoin, and 3 ounces of water, emits a perfume much resembling the flower Acacia.—*Exch.*

FOR BALDNESS.—Bartholow advises :

Ext. pilocarpi fl.	3 i.
Tinct. cantharid.	3 ss.
Lin. saponis.	3 iiss.

M. Sig. Rub into scalp thoroughly daily.

NEW EXCIPIENT FOR MERCURIAL OINTMENT.—Dr. Yvon propose to substitute soft soap for lard. The soft soap mixes more thoroughly with mercury, and is soluble in water. Mercurial ointment prepared with soft soap can be kept for an indefinite time, neither does it melt when exposed to heat. It does not irritate the skin, and is easily removed by soap and water.

HYPERIDROSIS.—Agaricine, in doses of one-sixth of a grain, to be repeated, if necessary, is an efficient remedy for excessive perspiration, and there appear to be no disagreeable or undesirable effects attendant upon its use.

INFANTILE ECZEMA.—In the *Rev. Thérap.*, October 1, the following preparation is recommended for the cure of infantile eczema :

R Vaselinei	3 i.
Picis liquidæ,	
Hydrarg. chlor. mit.	āā 3 ss.

M.

Apply two or three times daily until cure is effected, unless the remedy becomes too irritating, when its use should be suspended for a short time.

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Original Communications.

DOUBLE COMEDO, DUE TO A HITHERTO UNDESCRIBED ANOMALY
OF THE SEBACEOUS DUCTS.

BY

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A REFERENCE to dermatological literature will reveal the fact that all authors are agreed in their description of comedo, in that it consists of a greater or less inspissation of sebum in a sebaceous follicle, and that by exercising moderate pressure about the periphery of the duct, a small plug of sebum is forced out, the outward extremity of which is colored black by some cause or other. And we learn, furthermore, from the observations of anatomists and of dermatologists that each sebaceous gland has but one duct, and that each duct is provided with but one orifice. At least, that is what a careful reading would lead one to infer. The condition I am about to describe is one so altogether different and apparently unique, although met with in two cases, that I have taken the greatest pains to assure myself of its existence, and have also been fortified by the independent observations of others upon the same cases. I am indebted to Dr. A. C. Bernays, of St. Louis, for the opportunity of seeing these cases, he having kindly referred them to me. Their histories, in brief, are as follows:

CASE I.—Mr. H. F—, aged 33, unmarried, is of Jewish extraction, and a marked brunette. His business is that of a commercial traveller. When about 23 years of age, he acquired syphilis of a mild type, and was subjected to no treatment at the time. He had always been healthy, and continued to be so until about 1879, when he consulted Dr. A. C.

Bernays about an eruption upon his back. The doctor, in his examination, noted mucous patches in the mouth at that time. He placed him upon proto-iodide of mercury, and continued it for about six months. The symptoms, however, kept growing worse. Some time after, he returned with excavated ulcers of the upper lip. These were treated locally with the cauter, and he was ordered a course of mercurial inunctions which resulted in an apparent cure, lasting for a few years. For the last two years, he has had mucous patches, syphilitic infiltration of the tongue, and various other manifestations of the disease. When I saw him, his back was the seat of an acne, the lesions were papular, pustular, and tubercular, and, in addition, a considerable number of comedones existed. As to the distribution, appearance, and peculiarities of these last, I will speak more in detail further on.

CASE II.—Mr. A. S—— is 32 years old, unmarried, and also of Jewish extraction. He is a very strong, muscular man, of a decidedly dark complexion. He acquired syphilis about seven years ago, but in a very mild form. Dr. A. C. Bernays, who treated him for that trouble, states that he did not observe any other secondary symptom but alopecia and mild squamous papules. He has remained apparently healthy since that time, being kept upon active mercurial treatment. His back is also covered with the eruption of acne in a papular and pustular form, together with tubercles here and there. Interspersed are numerous comedones having the same peculiarities as those in Case I., and which will now be described.

The comedones, in both cases, are well-marked, the skin not being elevated at the sites where they exist. The black points are very distinct, and they occur between the lesions of acne. The distribution of these comedones is all over the back, though inclined to be discrete. One peculiarity of the distribution is that many of them are apparently in pairs, the distance between such varying from one-eighth or less to about three-sixteenths of an inch. If the skin intervening between the two points be carefully examined, it feels as if there was something beneath it of a cylindrical shape, of a diameter a little in excess of that of an ordinary pin, and apparently lying horizontally. By bringing somewhat firm lateral pressure upon one of the comedones in the direction of the other, it will be seen that the latter projects somewhat, and, by continuing the pressure, both follicles are emptied, and a "double" comedo is the result; that is, we find that there is but one plug, and that it is black at both extremities, as shown in Fig. 1.

Taking a fine probe (a piece of silver wire or a blunt pin) and introducing it at one opening, it is found that it will appear at the other opening, and project out of it, as shown in Fig. 2.

Here and there are to be found, scattered over the back, long black

hairs, each one occupying a solitary position. The development of the glandular system is somewhat above the average, and the acne, which is present, has been very rebellious to all forms of treatment.

These cases present many interesting points for our consideration. It is a question, in the first place, as to what effect the syphilis has had in the production of the acne or in the prevention of its cure. That the eruption on the back is not syphilitic, all who have had an opportunity of seeing the cases are convinced of. The appearance of the lesions and their chronicity, together with other characteristics of acne which are



FIG. 1.

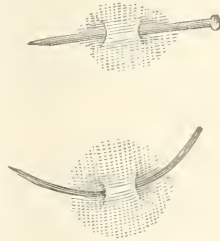


FIG. 2.

present, preclude any mistaken diagnosis. The presence of comedones, moreover, is confirmatory proof. What rôle the syphilis could have played in the anomalous condition of the sebaceous follicles is a question difficult to determine. The fact of its existence, of course, does not necessarily make it causative; but the very fact of its having been present leaves room for doubt.

The most interesting point, of course, is the double comedo and its plug. This latter is composed of one piece, cylindrical in shape and each extremity black. Moreover, vertical pressure over one opening will only result in pressing out a portion of the plug torn off, as it were, from its other half. Lateral pressure continued in the same direction has always been successful in forcing out the double comedo entire and apparently intact. This fact naturally brings up another question, and a most important one, connected with the sebaceous gland and its duct. Have we here to deal with a congenital anomaly or with an acquired defect? Are there two outlets to the same gland or has the duct separated just before reaching the surface of the skin? A third possible condition would be the uniting of the ducts of two glands at some point beneath the surface. It is impossible to answer, definitely, these questions at the present time. The question of a pathological or of a congenital origin might be resolved by the same means which we would adopt to determine the exact condition of the parts, that is, by microscopical examination. As neither one of the gentlemen has yet consented to permit the excision of a sufficient amount of skin to determine these points, they cannot be dwelt upon

here. It is to hoped, however, that one or the other will accede to the request and thus furnish a satisfactory solution to these interesting questions.

That the two openings connect with each other does not admit of a doubt for a moment. The fact that the plug which is forced out is unbroken is evidence of this. And the further fact that a fine blunt probe can be easily passed into one opening and out at the other, without using any force or disturbing the tissues in the least, except the slight elevation of the bridge of tissue connecting the two openings, is a very strong and indisputable argument establishing, in the clearest manner, the condition which has been described. This condition is, in my experience, a very rare one. I have repeatedly examined a number of cases of comedo to find a similar state of affairs, but unsuccessfully. Those whose attention I have called to this have also failed to find it; and nowhere in literature can I find the record of a similar condition.

A few interesting coincidences exist in both cases. The patients are of about the same age, have dark complexions, are of Jewish extraction, have had syphilis of a mild type, and have only the back implicated by aene. They have about the same form of the disease, and it is equally intractable in both. The glandular system of the skin is well developed in both, and they are well-developed men. Not the least curious is that two such cases should be seen at about the same time.

In conclusion I wish to state that Drs. A. C. Bernays, Geo. Bernays, W. F. Thornton, Chas. Barek, and others have seen and examined these cases, in my presence and out of it, and that they corroborate my observations, so that the personal equation of probable error due to defective eyesight, improper manipulation, or unconscious deception, did any of these exist, cannot be taken into consideration.

A CASE OF "RUPIA SYPHILITICA," CONFINED ALMOST EXCLUSIVELY TO ONE SIDE OF THE BODY.

BY

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AUGUST 5, 1885, I was requested by Drs. Lester to attend Mrs. C., who had been suffering from a skin trouble for some months. The patient was 44 years old, of medium frame, much emaciated, sallow complexion, nervous, and somewhat inclined to be hysterical. Upon an examination, I found an ulcerative eruption confined to the

right side of the body and a space of about one-half inch in diameter, on the left side of the face. (The character of the ulceration will be given, with the history elicited from the patient and her husband several days later.)

The patient's family history was good. She had several of the diseases incident to childhood. At the age of 17 she was quite strong and fairly well developed, at which time she was married to her present husband. Her first child, a male, was born in 1860. The mother says that he was always healthy until his 11th year, when he died of typhoid fever. The second child, born two years later, died from whooping-cough, age 11 months. The third child, born in 1868, was well nourished, strong, and hearty, and always enjoyed good health until 1873, when it died of small-pox. In 1873, she again conceived, but between the second and third months produced abortion with the aid of instruments; the same procedure was resorted to in 1875 and 1877. She stated that she suffered but little from the first and second abortions. The third confined her to her bed for some weeks. After her last illness, in 1877, she recuperated rapidly and remained in fairly good health until some time in July or August, 1882, when she became subject to dizziness and fainting spells, the latter coming on suddenly, lasting a moment or more, then passing off equally as rapidly.

In October, 1882, the *left* eye became inflamed, the pain being continuous and of a throbbing, lancinating character, and most violent between the hours of 9 P.M. and midnight. The doctor, she states, informed her that an ulcer was passing over the eye, and that it began at the outer side of the pupil and extended inward toward the inner canthus. The condition of the eye did not improve until four months had elapsed; after that time it continued to improve until July, 1883, when she was able to attend to her household duties. December, 1883, the same eye became again inflamed, the attack coming on suddenly; it grew worse until the middle of March, 1884, when vision had completely disappeared. April, 1884, the eye improved and continued so until September, 1884, when she could read large print with the same. The symptoms during this attack were the same as in the previous one. November, 1884, she became subject to rheumatic pain in the joints, pain over the tibia, and painful contraction of the muscles of the calf of the limb. This condition continued until December, 1884, when the first indication of skin trouble in the form of a pimple appeared midway between the ankle and knee-joints. It was accompanied by intense burning pain and severe itching. Soon a pustule formed in the centre of the pimple and dried into a crust. A few days later, the crust was removed, when an ulcer was found beneath. The ulcer extended peripherically until it acquired the dimensions of a silver quarter of a dollar, when it began to heal in the

centre. August, 1885, it was $2\frac{1}{8}$ by $1\frac{1}{2}$ inches; the edges were irregular, gyrated, and covered with thick dark crusts, which, when removed, exposed a deep ulcerated surface with a grayish base and very painful to the touch. December 16, a pimple formed anterior and inferior to the external condyle of the tibia, the symptoms and course of development being precisely as in the former, excepting its contour was semicircular. December 18, a small group of water-blisters, resembling in form a strawberry and accompanied by burning pain and severe itching, appeared on the surface over the base of the metacarpal bone of the thumb. The vesicles were lacerated by scratching, the part then became ulcerous, and followed the same course as the above. The ulcer, when seen, was oblong, 1 by $\frac{3}{4}$ inch, and irregular edges. She attributed the water-blisters to a blow, stating that soon after the occurrence of the accident a red spot made its appearance, which became purple and was followed by the vesicles; the part did not become ulcerous until four weeks following the injury.

December 27, a pimple appeared on the outer side and middle of the ulna, and another on the inner side over the condyle of the humerus. The symptoms and development were as in the former; they acquired the size of $2\frac{1}{4}$ by $1\frac{1}{8}$ and 2 by $1\frac{3}{8}$ inches; the former somewhat kidney shaped, the latter irregular and semicircular. January, 1885, a few pimples developed over the upper third of the humerus and scapula, and several on the thigh. Of the former, one became quite large and distinctly kidney-shaped. In February, a number of papules appeared on the scalp, right side, and limited to the space between the supra-orbital bone, parietal and lambdoidal sutures, also a few papules on the right side of the face and on the ear. Several days before, the spoken of papular eruption on the right side of the face and scalp made its appearance. A small group of papules developed on the *left* side of the face, and involving a space of about an inch square between the angle of the mouth and the nose. None of the symptoms experienced in the former attack were experienced in this case, such as burning and itching; the development progressed as in the former. In May, the last papule appeared, located on the small toe of the right foot; itching absent, burning severe. Mrs. C. suffered intensely from the spasmodic contraction of the muscles of the right foot and leg from the knee down, and forearm and hand; the attacks coming on suddenly, and especially before midnight, without any apparent cause, and lasting from fifteen to thirty minutes. During these attacks, the above-mentioned parts became rigid, with severe pain in the back part of the head and neck, and, as she states, the ulcers felt as if a hot iron was being pressed into them. The thigh and arms were not affected in the above manner. There was enlargement of the right epitrochlear glands, not the left, and the glands of the neck both sides.

Mr. C., the husband, always enjoyed good health until seven years after his marriage, 1866, he contracted from an impure intercourse a venereal disease, which manifested itself, about eight days following the coitus, as three small ulcers on the prepuce; they were soft and painful, much inflamed, discharge slight. The inguinal glands were slightly enlarged, and somewhat painful. The treatment consisted of "black wash" locally, and potas. iodide with mercury internally. The ulcers were cured in three weeks, and the treatment was stopped. In 1872 had a group of vesicles form on prepuce, with symptoms of burning and itching (herpes preputialis), which were cured in ten days with application of sulphate of copper, and the same year he also contracted gonorrhœa, followed by stricture and fistula, both cured after months of treatment. In 1873, had a papular eruption on the backs of the hands, which later became pustular and ulcerative; it remained in the latter state for seven months. During the last four weeks of this time, large doses of the mixed treatment were taken, to which the disease yielded. No local applications were used. The result of the eruption is still visible as white atrophic spots and cicatrices from the size of a hempseed to a split pea or larger. In 1880, he suffered from ulcerative sore throat, in 1883 had severe rheumatic-like pain confined to the tibiæ of both limbs, most severe during the night. The pain was relieved by taking 30 gr. iodide of potash three times a day. August 5, 1885, had psoriasis palmaris of both hands, and mucous patches at each angle of the mouth, and a node on the tibia of the right limb. He was placed on an anti-syphilitic treatment nine weeks since. The psoriasis of the hands and mouth, and the papules have yielded to the treatment. The mucous patches were also treated with spray of iodoform. Mrs. C.'s case was diagnosed as rupia syphilitica. She was given mixed treatment, and the ulcers were dressed with emplastrum hydrarg. The disease yielded rapidly to the treatment, and within three weeks after treatment had begun, the greater number of the old ulcers had healed, and in five weeks they had all cicatrized completely. Five days after taking treatment, the muscular contraction and pain had ceased.

MICROCOCCUS OF VAGINITIS IN CHILDREN.—In the vaginal secretions of 26 children, from three to ten years of age, treated in the Pesth Children's Hospital for various chronic diseases, Dr. Cseri found a coccus identical with Neisser's gonococcus and with that found in vaginal gonorrhœa. Many cases of chronic catarrhal vulvo-vaginitis are infectious. The spreading of this disease in children's hospitals takes place by means of washing, bath-tubs, closets dressing, and the nurses themselves.

RECENT PROGRESS IN THE TREATMENT OF CHANCROID.

BY

CHAS. W. ALLEN, M.D.,

Surgeon to Charity Hospital.

THE multitude of remedies constantly suggested, advised, or urged in the treatment of chancreoid is an indication of the degree to which this form of venereal sore can be at times rebellious. The most obstinate form of the chancreoid is that designated as phagedenic.

Recently Spillman, of Nancy, has treated several cases of this variety by first scraping thoroughly with the sharp spoon or curette, excising the undermined edges with scissors, cauterizing with the thermo-cautery, and dressing with diluted liquor of Van Swieten. Among the cases so treated was one of a medical student who had inoculated himself with the pus of a soft chancre on the anterior surface of the thigh. The thigh, lower part of the abdomen, and the scrotum became involved in an extensive phagedenic sore.

Various forms of treatment, from the use of iodoform to prolonged hot baths, were tried, with no effect.

The treatment by scraping, etc., was rapidly followed by a cure in this as in the other cases.

TO ABORT SOFT CHANCRES.

Hebra advises as follows:

Thoroughly cleanse the sore, treat with a preparation of potash-soap and spirits, dry carefully, apply pure salicylic acid, and cover with a plaster.

This treatment succeeds best when the application is renewed on two succeeding days, and the sore suppurates freely. After three days, a white scab covers the sore.

An emollient ointment is now to be spread on lint, and applied. Under this, the scab speedily separates, and the wound heals without any bubo formation.

TREATMENT BY IODOFORM.

Iodoform is one of the most valuable applications in the slowly destructive forms of chancreoid. Its use, however, in private practice is almost impossible, unless in some way the odor be destroyed or disguised.

Men object to it from reason of its *give-away* perfume, and public women will not submit to its application as it keeps the men away from the house.

Only in the *virtuous*, therefore, can it be used pure without opposi-

tion. Iodoform has now so wide a range of application outside of venereal diseases that it is to be hoped these prejudices will soon disappear.

INODOROUS IODOFORM.

To render iodoform inodorous, several methods are recommended. Thus, at different times, tincture of musk, one drop to each forty grains, or oil of thyme, with the addition of a little thymol.

Dr. Schenk claimed, in the *Pharm. Zeitung*, 1882, that if one hundred and fifty grains of iodoform were rubbed up with one grain of carbolic acid and two drops of oil of peppermint, the odor would be so masked that it would not appear again even on heating.

Dr. Catillon has recommended the addition of tonka bean fragments to the iodoform bottle. This imparts an odor of bitter almonds, which, however, is lost after a few days' exposure to the air.

Dr. Andrews, of Staten Island, N. Y., says that cumarin, a derivative of the tonka bean, will completely cover the odor if added in the proportion of three grains to the drachm.

Balsam of Peru masks the odor in a measure.

Dr. Oppler claims that forty or fifty per cent of well triturated, freshly-roasted coffee will absolutely deodorize it.

According to the *Lancet*, Dr. Gillette has recently found that one part of sulphate of quinine and three parts of charcoal to one hundred parts of iodoform effectually accomplishes this result.

Dr. Krieger (*N. Y. Med. Record*, January 2, 1886) makes use of the ethereal oil of sassafras, a few drops of which, he says, suffice to remove entirely the offensive odor, and substitute therefor an agreeable aroma. I have made trial of this method of disguising the odor, and so far as my observations have gone, it does so entirely. I have succeeded with the non-ethereal oil (two drops to the drachm) in completely substituting the odor of sassafras for that of iodoform.

Prof. Morrow, in his recent work ("Venereal Memoranda," New York, 1885), after referring to the various expedients which have been employed for masking the odor of the drug, says (page 286), "I have found that oil of erigeron effectually disguises the odor for a time."

None of the odorless iodoforms have appeared to me to fully warrant their being so designated. Delicate olfactories will detect the peculiar odor sooner or later, in spite of any combination with which I am familiar.

I have recently tried the admixture of charcoal and quinine, and fail to find that it covers the odor to any marked degree.

Again, none of these combinations can equal in efficacy the pure iodoform, and it may be possible that some substances which destroy the smell may at the same time take away its principal virtue, as is the case with colorless tincture of iodine, and it is quite probable that the bad

results and ill-effects which have at times followed the use of iodoform have been due to its use in improper combinations. The solutions of iodoform in collodion appear to act well for a time, but as the ether evaporates the iodoform deposits in the bottle, the solution becomes darker in color, and loses to a great extent its characteristic odor, and does not produce the same effects as when fresh. A coat of the iodoform collodion whilst fresh has almost as strong an odor as the powdered drug.

The application of the collodion dressing is attended with some pain, and in the case of a large ulcer I have known it to be almost unbearable. To obviate this, the sore or ulcer may be covered with pure powdered iodoform; a thin layer of absorbent cotton is now applied over the sore, and over this is painted several layers of the iodoform in collodion. This forms a comfortable and efficacious dressing. If now it is desired to cover the odor of the iodoform, several layers of plain flexile collodion is painted over the whole. This will be found to give better satisfaction to the patient, and better results than any application of so-called odorless iodoform.

I have had such a dressing stay on a large syphilitic ulcer of the leg twenty-two days in a patient who was forced to make a journey in which he could not well dress the ulcer daily. On his return, I found that the ulcer was less than one-half the size when he started, the discharge being taken up by the absorbent cotton, which in this case I applied in a thick layer.

He was taking constitutional treatment at the same time.

ADULTERATION OF IODOFORM.

Attention was recently called, by the *Journal de Pharmacie et de Chimie*, to the adulteration of iodoform by picric acid, which is a cheaper drug, while possessing many properties in common with iodoform. Besides being a poison, it is capable of exploding when triturated in a mortar. Its detection is easy. When suspected iodoform is shaken up in cold water, it imparts to the water a yellow color. The addition of a little cyanide of potash to the filtered liquid produces no effect if the iodoform be pure. If picric acid be present, on the other hand, after ten minutes a brownish-red color appears, due to the formation of isopurpuric acid, and after a still further delay, a brownish-red precipitate of isopurpurate of potash takes place.

PYROGALLIC ACID.

I have recently called attention to the beneficial action of pyrogallie acid in the treatment of chaneroids. This was first recommended by Vidal, of Paris, whose good results led others, among whom were Teril-

lon and Mauriac, to make extended trial of the drug. Vidal recommended a powder composed of one part of the acid and four of starch. I have used and recommended the application of the pure powder to be first applied and covered over with a layer of traumaticine, or a solution of pyrogallie acid in collodion.

CAUSTICS.

Of all caustics, the hot iron or thermo-cautery is probably the best for the majority of cases. With it we produce just the amount of cauterization we desire.

It can be used where other caustics would be dangerous, as in the vagina.

The pain produced, though severe, is of much shorter duration than that from chloride of zinc or nitrate of silver.

Since the introduction of cocaine into venereal surgery, the Paquelin cautery has lost its terror for the patient. Bono (*Gaz. delle Cliniche*, ii., 1885) says: "In cauterization, cocaine showed every desirable analgesic property of a sufficiently long duration."

Latouche (*Rev. de Clinique Méd.-Chirurg.*, January, 1885) strongly favors the thermo-cautery at a dull red heat, especially for chaneroids of the vagina and neck of the uterus. He gives a number of cases in which the cure was complete in from eight to thirty-three days.

HOT BATH.

Dr. Aubert, of Lyons, has recommended prolonged hot baths as a means of treating chaneroid.

Martineau and Lormand have carried out some experiments at the Lourcine Hospital in Paris, on the effect of baths at about 104° F. on chaneroids and buboes.

They found that in all the cases the virulence quickly disappeared, and that auto-inoculation gave negative results after one or more baths in all cases excepting one, where the chaneroid was within the urethra.

They approve of the treatment for severe cases, finding it quite practical, and that it hastens the cure in all cases.

Wet compresses should be put upon patient's head while in the bath, and an attendant be present for fear of syncope. It is not necessary to submerge the whole body.

SPONGE GRAFTING.

Dr. Pokrovsky applies fine slices of the best Turkish sponge, washed in a three-per-cent solution of carbolic acid, to chaneroids and chancroidal buboes, and finds that this treatment brings about rapid cleansing and healing in about ten days. In syphilitic cases, the sponge dressing gives

rise to rapid cicatrization only after the syphilitic virus has been mitigated by specific treatment; otherwise the application of sponge causes disintegration of the tissues.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

159TH REGULAR MEETING, DECEMBER 15, 1885.

DR. W. T. ALEXANDER, *President, in the Chair.*

DR. ALLEN presented two cases of

PSORIASIS TREATED WITH PYROGALLIC ACID.

F. A., 41 years old, for the past nine years has had psoriasis. On Nov. 17 last, when first seen at the Hospital by Dr. Allen, the whole body, as well as the palmar and dorsal surfaces of both hands, were covered with a typical psoriasis. Pyrogalllic acid in collodion was applied to the surface, and in about a week after, he was suddenly seized with pain in the heart of a "grasping" character, together with great dyspnoea. This disappeared under the use of digitalis and whiskey. Two weeks later he complained of colicky pains in the stomach, preceded by a chill, and accompanied by nausea and vomiting and great prostration: these symptoms also disappeared under appropriate treatment. At present the eruption has almost entirely disappeared from that portion of the surface to which the pyrogalllic acid was applied, and the skin is pliable and soft.

The second case, M. K., 60 years old, has had psoriasis for over thirty years. He was first seen by Dr. Allen last month, who gave him Asiatic pills, as many as ten each day, without any apparent benefit. About ten days ago, pyrogallol in collodion was applied to a portion of the body, and since then the eruption has cleared up faster there than elsewhere.

Discussion of Dr. Allen's paper

ON SOME OF THE USES OF PYROGALLIC ACID IN DERMATOLOGY AND THE DANGERS ATTENDING ITS APPLICATION.¹

DR. SHERWELL said that he had relatively little experience in the use of pyrogalllic acid. He had been very cautious in applying it, and in his hands it had not produced such satisfactory results as other drugs, chrysarobin for example. He would like to ask the reader of the paper, when he speaks of mixing castor-oil with collodion, if he uses the flexile or contractile collodion. (Dr. Allen replied that he used the contractile.) He, Dr. S., suggested the use of pyrogalllic acid in mild forms of moist eczema, dusting the surface with the powder.

DR. JACKSON has used pyrogalllic acid in some cases of epithelioma and of lupus, and with satisfactory results. Some of the cases had been treated with the curette and by boring out with nitrate of silver stick without curing them. Under the pyrogalllic acid in ointment, followed by mercurial plaster, they healed. He has noticed that, in the strength of ten per cent in ointment, the acid did not

¹ Published in January number.

attack the hard edge of the ulcer, and he had to use there the nitrate of silver. He regards pyrogallic acid as a useful means of treating these affections where, for any reason, they cannot be operated on. He has also used the drug in psoriasis, and in chronic thickened patches of eczema, but it did not act so promptly as chrysarobin. Fearing its toxic effect, he has never used it in extensive cases of psoriasis.

DR. FOX had used pyrogallic acid constantly for several years. It was valuable in certain carefully selected cases, but it did not act as well as he would wish. He had used it in superficial epitheliomata and small patches of lupus. He first curretted with the object of removing most of the disease, and then used a ten or twenty per cent ointment of pyrogallic acid, afterward applying mercurial plaster. Deep epitheliomata of long standing and with infiltrated and cartilaginous edges could not be destroyed with pyrogallic acid, even where used for a long time. He found that in such cases an arsenical paste was infinitely superior. In the treatment of psoriasis, pyrogallic acid is not as good as chrysarobin, but where it is desirable not to stain the skin, or when the psoriasis is superficial, he uses ten to fifteen per cent of pyrogallic acid, three to five per cent of salicylic acid in solution either with the tincture or compound tincture of benzoin, which he had found preferable to collodion, as it is more pliable after drying. In mild cases of psoriasis, he has covered half the body with this solution without producing any bad effects, except a slight dermatitis. He has seen unpleasant local results follow the application of a twenty-per-cent ointment of pyrogallic acid to a raw surface. He has also used the acid in chromophytosis and other skin affections. In conclusion he would say that there are many cases of both epithelioma and psoriasis in which he would not depend upon its action for a cure.

DR. LEWIS said that he had used pyrogallic acid in some cases of epithelioma. In one case in particular he curretted and then applied pyrogallic acid ointment for a long time, finally using it in powder in full strength without much benefit. He came to the conclusion that it would not affect the indurated border of an epithelioma and also that it was too slow in its action. He considered it important in epithelioma that the action of the drug should be quick, and the healing take place as rapidly as possible.

DR. MORROW had considerable experience with pyrogallic acid in the treatment of psoriasis, and it was not unlike that of Dr. Fox. He spoke of several cases of psoriasis that he had treated in Charity Hospital, in which he applied pyrogallic acid collodion to one-half the body and painted the other with chrysarobin in traumaticine. He found that the action of the chrysarobin was more prompt and pronounced than that of the pyrogallic acid. Where there exists a peculiar susceptibility to the irritant action of chrysarobin, as is often found, pyrogallic acid may be substituted with advantage, although it is undoubtedly less effective. In epithelioma and lupus he uses a ten to twenty per cent ointment, or the powder, either mixed with some inert substance, or in its pure state. He differed with the members who asserted that the hard and everted edges of epithelioma were not affected by pyrogallic acid when used in its full strength. He, however, did not get such brilliant results as would lead him to use it in preference to other caustics. In regard to the dangers attending its use, he thought that they were slight indeed; he had never seen constitutional symptoms follow its absorption; in some cases there might be a mild erythema or slight dermatitis. He considered it to be much less irritating than chrysarobin.

DR. TAYLOR had employed pyrogallic acid in collodion for a long time in psoriasis, and in some cases of infiltrated and scaly eczema, but did not consider it as good as chrysarobin. He had also used one part of pyrogallic acid to three of bismuth in soft chancres and gummatous ulcers.

DR. ALLEN, in closing the discussion, said that he had never applied pyrogallol in moist eczemas, but had used it in the scaly forms which resembled psoriasis. In almost all cases of epithelioma and lupus, it was best to have the surfaces denuded before applying the pyrogallic acid. He thought that the chances of producing a dermatitis were less than when chrysarobin was used, and the drug could be employed for a longer time. He has had very much the same experience that the other members have had in producing an effect on the hard and everted borders of an epithelioma, although in one case pyrogallic acid appeared to reduce the hardening to a slight extent. The pyrogallic acid was chiefly applicable to those cases where there was excessive cell proliferation and where there was

a low vitality, or where chrysarobin is apt to produce a dermatitis, or does not act well in other respects.

He then gave the history of a case of supposed lupus of the nose occurring in a colored woman, 26 years old. She was first seen June 24. Two years ago, a sore appeared on the mucous surface of the nose, and was followed by ulcerating sores on its external surface. When first seen, the organ was twice its normal size, fissured, and warty-looking. The diagnosis was between syphilis and lupus. She was placed on the mixed treatment, and mercurial plaster applied; this was used for a month without much benefit; then pyrogallie acid was employed locally from August until October, together with the mixed treatment, which caused the skin lesion to disappear more rapidly. In the beginning of October, the mixed treatment was discontinued, because it could not be tolerated by the stomach. After that, pyrogallie acid, forty grains to the ounce, was employed, and early in November the nose was less than one-half the size it was when first seen. Now the patches are dry and scaly, and there are small tubercular spots, like lupus, which readily break down when the slightest force is employed. The question arises whether the pyrogallie acid would have acted so well if the lesion had been syphilitic.

In a case of alopecia areata, which had been under treatment without benefit, he, after shaving off the hair, applied pyrogallie acid, one drachm to the ounce. In five days there was decided improvement, and in a month quite a good crop of hair was growing. It may be that pyrogallie acid has the power of destroying the parasite which Von Sehlen claims to have found in every case of alopecia areata, and to have succeeded in cultivating it.

The advantages claimed for pyrogallie acid, used as a fixed dressing rather than in the form of ointment, were that it is much cleaner, easier of application, and that it excludes air and moisture, which, in some cases, might interfere with the cure of the disease, and it is not so apt to produce toxic effects as the ointment.

DR. FOX referred to a case of

ALOPECIA AREATA TREATED BY STATIC ELECTRICITY.

When the patient was first seen, two weeks ago, there were no signs of hair in the diseased patches. Within a week after the first application of electricity, a number of fine hairs had made their appearance.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

Impetigo; Its Contagious and Parasitic Nature.

DR. DEWÈVRE has just published in the *Archives de Médecine et de Pharmacie Militaires*, September 16, 1885, quite a lengthy memoir on the contagious and parasitic nature of impetigo. The contagious nature of this dermatose is shown to his satisfaction by both rational and experimental proofs.

First. Rational Proofs.—Most authors agree that scratching favors the dissemination of the affection in the highest degree. It appears especially upon the unprotected parts, in particular upon the face and about the mouth. It has a marked predilection for children and for those who have no regard for cleanliness.

Second. Experimental Proofs.—The clinical observations are numerous in which the transmission of impetigo has taken place to a healthy subject from one sick with the disease. Dewèvre cites in support of this statement the cases and works of Devergie, of Tilbury Fox, Wilson, Anderson, Taylor, Kaposi,

Neumann, Duhring, Piffard, Stellwagon, Van Harlingen, Wooster Beach, and others. The author reports seven unpublished observations of his own. On several of these patients, he has carried out such auto-inoculation experiments as Vidal had already done in 1877. Out of five inoculations, made with the contents of the vesico-pustule as soon as it was formed, he had one positive result. Out of five inoculations with the finely powdered impetiginous crusts, he obtained two positive results.

Out of five inoculations with the pus from beneath the crusts, there were four positive results, and when the product of scraping the ulceration, which had been previously cleaned, was employed, all five inoculations succeeded. All attempts to inoculate animals (guinea-pig, dog, horse, rabbit) failed. The pus and the products of scraping are the contagious elements *par excellence*. Clinical history and experimentation appear then to prove the inoculability and the transmissibility of impetigo from the sick to the well.

The parasitic element of this affection has been sought for. The author calls to mind the rather contradictory results arrived at by Kohn, Piffard, Geber, and Duhring, and believes that these differences of opinion can be explained by the fact that some have looked for the parasite in the crusts and others in the vesicles. Now the experiments of Dr. Dewèvre show that you must look for the parasite especially in the product of scraping of the ulceration after it has been well cleaned. In examining this product under the microscope, after suitable preparation, you find tufts of tubes of mycelium entangled together in such a way as to form a veritable network.

These tubes have a thickness of about three-thousandths of a millimetre, are readily colored, and show by transparency the spores with which they are filled.

The parasite seems to occupy the rete Malpighii. The author has made other experiments which would go to prove that the current of air passing over the impetiginous crusts can carry along with it morbid elements and produce at some distance an eruption of impetigo on an excoriated surface. Impetigo affects especially healthy subjects and it has a predilection for those recently vaccinated, as Dr. Piffard has already pointed out. Dr. Dewèvre thinks we should completely reject the opinion of many American and English dermatologists that there exist two distinct varieties of impetigo; impetigo contagiosa, and impetigo vulgaris. It is on the whole a very interesting paper, containing, however, some conclusions which need to be confirmed by subsequent research.

Furunculosis.

In an excellent article which appeared in the *Bulletin de Thérapeutique*, Dr. Guigeot in a masterly way laid down the rational treatment of the furuncular affection. There are, according to him, scarcely ten years that we have had any exact notions on the real nature of the boil. It is a contagious affection which has twice been successfully inoculated (Lannelongue) and which appears to be caused by a vegetable parasite, *torula pyogenica* (Pasteur and Löwenberg). The evolution of this disease is completely modified by the nature of the soil on which it develops. Starting with these etiological propositions, Dr. Guigeot shows how little rational were the therapeutic methods formerly held in honor; early incisions, poultices, simple baths, local bleedings, etc.

Parasiticides must be employed as topical applications; the acid nitrate of mercury and carbolic acid have given good results, but the substance which the author has found by far preferable is the tincture of iodine. A thick application must be made to the whole part affected, encroaching upon the surrounding

healthy skin. The layers must be painted one upon another, until there is produced a staining of a dark-brown color. Unless this is done, the treatment may not succeed. You can thus obtain a complete resolution if you make the application early enough; in any case you will always greatly diminish the intensity of the pathological process. You should also paint with tincture of iodine all other cutaneous lesions which may develop in patients suffering from furuncles, for if this precaution is neglected, these may also become furuncular. If the employment of tincture of iodine on the face is objectionable on account of its color, it may be replaced by camphorated alcohol. Finally, if the case is a severe one, we have recourse to the acid nitrate of mercury or to carbolic acid.

The furuncles, after being opened, may be dressed with borated water or borated alcohol. Internally, the author advises the administration of the hyposulphite of soda dissolved in a large quantity of water, as Dr. Bulkley has used it; or the preparations of sulphur, which he considers much more efficacious. He uses habitually Pouillet's powder, of which he gives from twenty to eighty centigrammes per day, either in milk or in pure water.

Ordinarily, it is necessary to continue the medication by sulphur a month at least, and to take it up from time to time in obstinate cases to prevent relapse.

Generalized Erythematous Exfoliative Dermatitis.

Dr. Thiry has communicated to the Royal Academy of Belgium (*Presse Médicale Belge*, Nos. 28-29, 1885) an interesting observation of the disease which, I believe, I first distinctly differentiated from the other morbid entities confounded under the term *pitryiasis rubra*. Together with my excellent and much honored teacher Dr. Vidal, I gave it the name of generalized exfoliative dermatitis or disease of Erasmus Wilson. Dr. Thiry calls it generalized erythematous exfoliative dermatitis. His case relates to a man aged 25 years, who was attacked about the first of April, 1885, with sensations of weariness, lassitude, febrile movement, loss of appetite, followed by a red eruption which soon extended over the whole body, and then became covered with a continuously scaly desquamation. Between the 10th and 20th of May, all the hairs of the body, head, lids, eyelashes, and beard fell out. Toward the middle of June, the redness and desquamation disappeared almost completely. The disease, however, was still prolonged by the complications of a rebellious blepharo-conjunctivitis, abundant diarrhœa returning several times, multiple abscesses, pulmonary congestion, marked weakness, and loss of flesh, delirium, especially marked at night, gangrenous patches on the toes, and finally erysipelas, broncho-pneumonia, and innumerable abscesses during convalescence.

The patient was only able to leave the hospital the last day of August. Dr. Thiry follows the interesting observation by some considerations of the nature of this rare affection, but as he has confined himself, with the exception of a few unimportant details, to a repetition of what was already said by me in 1882, I will not dwell further upon it.

Recurrent Scarlatiniform Erythema.

The last publication of Dr. Perret (*Lyon Médical*, Nos. 29, 30, 31, 1885) likewise treats of a subject to the elucidation of which, I believe, I contributed in a memoir which appeared more than a year ago in the *Archives de Médecine*. I was

indeed much astonished to see that Dr. Perret did not mention my work, and I can only believe that he was not acquainted with it when he wrote his article, for otherwise it would be altogether incomprehensible. As this memoir presents nothing new, but on the contrary omits important points, I would engage the reader who desires to gain further knowledge of the question to turn to the number of August, 1885, of this journal, where he will find in extenso the description which I have given of this affection.

The Treatment of Keloid.

An interesting discussion recently took place, on the subject of keloid, in the Surgical Society of Paris, following the presentation of a case by Dr. Monod. The majority of the members who took part: Monod, Ledentu, Reclus, Berger, and Tillaux, opposed the total ablation of the tumor, largely done with the bistoury, because each time that they have practised this operation they have seen relapses follow. Drs. Lefort and Lucas championed the operation, believing that it should be done when the tumor is pediculated, voluminous, and when it greatly annoys the patient.

Dr. Reclus cited a case in which he had obtained great amelioration by local compression with mecurial plaster (*emplâtre de Vigo*), salt baths, and cod-liver oil in large doses internally. Dr. Ledentu and Dr. Berger also spoke of *crossed* linear scarifications carried out according to the method of Dr. E. Vidal. So far as I am concerned, I am convinced that this last procedure is by far the best, or if you prefer the least objectionable, only you must know how to apply it. Each week parallel linear incisions must be made through the whole thickness of the tumor, and passing beyond its borders, and these must be crossed at right angles by other similar incisions, in such a manner as to form little squares. According to my idea, these incisions should be as close together as possible, say two millimetres. In the intervals between the operations, *emplastrum de Vigo cum mercurio* should be kept constantly applied. I have already treated three keloids after this manner. In the first case, the tumor was very much reduced in size, but did not entirely disappear despite a great number of operations. In the second case, where we had to do with two keloid tumors of the right cheek, consecutive to caustic applications, eight scarifications have been sufficient to cause their disappearance, but I am keeping the patient under observation, expecting a recurrence of the disease.

The third case is one of enormous keloid, having a diameter of ten centimetres in all directions, and a thickness of one and a half centimetres, situated a little above the pit of the epigastrium. Here I have already done more than forty scarifications, obtaining a diminution of at least five-sixths of its thickness, but I am far from having produced a complete disappearance of the growth. One of the great advantages of scarification in keloid, an advantage upon which Dr. Vidal has insisted, is that of rendering the keloid indolent when it is causing suffering to the patient, which it not infrequently does.

Treatment of Tinea Tonsurans by the Method of Fontis.

A fact which has struck me since I have been keeping up with the work done by Americans and English, is the facility with which you radically cure parasitic affections of the scalp, favus and tinea tonsurans, by the use of parasitocides alone without having recourse to epilation, while in France we obtain by your method only apparent and transitory cures. If we do not employ epilation, we always

have relapses. Then again, there is the treatment of Fontis (*British Medical Journal*, March 14, 1885) by frictions with the spirits of turpentine followed by applications of tincture of iodine, which has just been experimentally tried at the St. Louis Hospital by Dr. Hallopeau without the least success.

The conclusions of this author are that the treatment of Fontis does not cure tinea tonsurans in double the time claimed; that it is very painful, that its application is difficult, and finally that it excites a violent inflammation of the skin. Dr. Lailler, who has charge of the special service for these affections at the St. Louis hospital, has met with the same results.

Resurrection of Blennorrhagia and the Value as a Parasiticide of Corrosive Sublimate Injections.

At the Congress of Grenoble of the French Association for the Advancement of the Sciences, Dr. Diday remarked upon the curious fact of observation that when a gonorrhœa, treated at a seasonable time by copaiba, does not completely cease if the medicine be stopped, we see the running appear again at the end of a couple of days and become more abundant than before the use of the balsam. He gives the following explanation: The specific medication diminishes the nutritive qualities of the soil on which the gonococcus flourishes, but if you cease to employ the copaiba before the complete disappearance of the microbes, they again find a urethral soil favorable to their growth, and complete their development.

Dr. Constantin Paul believes that the best means of curing gonorrhœa consists in giving injections of corrosive sublimate at a temperature of 104° F. Dr. Spillman, on the other hand, has found no advantage arising from the method, as his patients could not bear the injections. Besides, Drs. Sinety and Henneguy have made experiments on the gonococcus of blennorrhagia, the result of which seems to be that permanganate of potash, oxygenated water, and corrosive sublimate exercise no specific action upon these micro-organisms.

Nature of the Chancroidal Bubo.

I have already made known, in one of my previous letters, the researches of Dr. Strauss on the virulence of the chancroidal bubo. Having had the fortune to meet with a lucky series of cases, this author concluded that the buboes which accompany the simple chancre are never of themselves virulent, but only become so after being opened and becoming inoculated by the pus of the chancroid itself. Dr. Geiny (*Annales de Dermatologie et de Syphiligraphie*, Nos. 8-9, 1885) has again taken up this question. He has made twenty inoculations with the pus of the chancroidal bubo, with all possible antiseptic precautions, and has obtained four positive, three doubtful, and thirteen negative results. He believes, therefore, that he ought to support Ricord's old theory, according to which the adenitis which accompanies a soft chancre is, in three-quarters of the cases, purely inflammatory. In the remaining one-quarter of the cases it is produced by the transfer of the micro-organism, the infecting agent, by the route of the lymphatics to the ganglion which becomes a chancroidal bubo. Dr. Strauss himself has returned to his former opinion. In a more recent communication, made to the Society of Biology, he presented new statistics showing that, out of 118 buboes recently inoculated in different hospital services in Paris, 6 were followed by positive results and 112 failed. The proportion of virulent buboes appears then to be smaller than the statistics of Ricord would indicate.

Treatment of Chancroidal and Syphilitic Phagedenism.

At the Congress of Grenoble of the French Association for the Advancement of the Sciences (*Semaine Médicale*), Dr. Spillmann, of Nancy, described a new method of treatment of phagedenism, both syphilitic and chancroidal. Believing that the phagedenic process is due to a peripheric infiltration of young elements and of colonies of microbes which compress the vessels, and thus disturb the vitality of the tissues, he thinks that treatment should have for its object the destruction of all infiltration capable of impeding the circulation, and to replace the phagedenic by a healthy wound. He also practises scraping the ulceration with the sharp spoon in all cases, and cuts off the overhanging borders with curved scissors; he then cauterizes with the thermo-cautery, and dresses the wound with a solution of corrosive sublimate, one to two thousand.

Lesions of the Buccal Mucous Membrane in Lichen Planus.

Dr. Ehibierge, in *Annales de Dermatologie et de Syphiligraphie*, treats of lesions of the buccal mucous membrane in lichen planus. Erasmus Wilson had observed small, white spots on the tongues of two of his patients. Hutchinson has noticed the same complication in two cases; Radcliffe Crocker has described them minutely; lastly, Pospelow and Neumann have each published an example of the kind. Dr. Ehibierge reports three very complete cases, and appends an accurate account of the symptoms. According to him, lichen planus may invade the buccal mucous membrane at an uncertain stage in its evolution—before, during, or after the cutaneous eruption. Usually, the membrane merely feels rough, without any pain, and the patient is only by accident made aware of the complication. In most cases the lesions are seated on the tongue and the internal surface of the cheeks; on the tongue they appear as round or irregularly-shaped white spots, not at all elevated, either solitary or united, and in the latter case forming parallel lines at the edges of the organ; on the cheeks they take the shape of small, pointed, round or stellated pimples, very white, sometimes shining, and either solitary or united, and forming patches, large or small, which may be scattered over the whole surface of the cheek, or, when extending far enough, may occupy the posterior portion in the vicinity of the last molars. Their occurrence upon the buccal mucous membrane is favored by local irritation of any sort; they persist for a longer or shorter time, but their tendency is always towards improvement, if not a complete cure.

Urticaria Pigmentosa.

M. Feulard describes, in *Annales de Dermatologie*, a case of that curious affection which has been the subject of observation in England and America, under the name of urticaria pigmentosa. It occurred in the person of a little girl 19 months of age, and began when she was $4\frac{1}{2}$ months old, by an eruption of large red pimples and whitish blisters, accompanied by very troublesome itching. This eruption was first noticed on the abdomen, whence, in the course of about a year, it gradually spread over the entire surface, and finally upon the face. When first seen by the author, the body was completely covered with brownish spots, varying in depth of tinge from that of *café au lait* to that of copper; in some places they were separately scattered, round or oval, and as large as a lentil or a fifty-centime piece; in others, confluent and forming irregular blotches. Their outline was plainly defined; they were slightly elevated, and when pinched between the fingers

imparted a sensation as if the derma were somewhat thickened. This was quite well marked in the case of the recent patches, which, under friction, would assume the exact appearance of nettle-rash. Older patches had a roughened aspect. In short, the disease was characterized by the production of urticarial patches, which underwent a gradual pigmentary change. The child was well developed, and its general health was perfect. The disease had apparently been growing less intense for several months past. While it remained under the author's observation (*i. e.*, during the year 1884) he could see that the urticarial patches became much less numerous, that those which were formed underwent no pigmentary change, and that the old patches by degrees flattened and faded. I have myself met with two other cases of urticaria pigmentosa, in the respective services of Professor Fournier and Dr. E. Vidal. M. Fournier's little patient was only a few months old, and had suffered from the malady almost from her birth. In many places the eruption was of a bullous nature; in others, unmistakably urticarial. M. Vidal's patient was older; he presented every degree of the eruption, and his case was particularly worthy of study; a very minute description of it will be soon published. Since examining this latter subject, I have been better able to appreciate the propriety of the designation urticaria pigmentosa, or xanthelasmaïdeia, which has been bestowed upon this singular skin disease; in fact, the older lesions which it presented upon the face and neck appeared precisely similar to the elements of xanthelasma tuberosum.

Colloid Degeneration of the Derma.

As likewise dealing with an affection of rare occurrence, I will call your attention to an article by MM. Feulard and Balzer on colloid degeneration of the derma. The subject of their investigation was a gardener, 40 years of age. In July, 1878, small yellowish blisters, slightly elevated, arranged in clusters, non-exuding and non-pruriginous, made their appearance over his left malar bone. In January, 1880, they extended to the other cheek, then to the bridge of the nose, and finally to the forehead. When first examined at the hospital, the eruption was scattered over the whole face, but was especially abundant at the above-mentioned localities. The affection is characterized by small, shining blisters, of a lemon-yellow color, of the size of a pin's head or of a millet seed; they appear transparent and as if full of serum, but after pricking them only a sort of yellowish jelly can be squeezed out. They impart to the skin an appearance as if grained. Histological examination has shown that this lesion is due to an infiltration of the derma by variously-sized lumps of colloid matter, generally situated in the spaces which separate the pilosebaceous structures. They do not come into contact with the epidermis, but remain divided from it by a delicate layer of normal connective tissue. This colloid infiltration seems to invade at first the conjunctive fascia of the derma, causing them to swell up and unite together into compact masses of different dimensions, which push back the surrounding healthy tissues. It forms in this way a sort of cellular deposit, which may be enucleated, as it were, by scraping. This, in fact, is the best mode of treatment. It is carried out, at one or more sittings, by the use of a small sharp-edged curette.

L. BROCC.

PARIS.

Selections.

THE SURGICAL TREATMENT OF CHRONIC ECZEMA.

THE surgical treatment of chronic eczema has, of late years, been frequently recommended without having met with special approval. This has been chiefly owing to the defects of the proposed methods, whose results have not been such as to tempt us from the usual path of medico-mechanical treatment. It is always possible, although only after a long treatment, and frequently after the occurrence and removal of several relapses, to cure chronic eczema completely, and without any tissue-lesion, by the use of medicinal and mechanical remedies; the affected integument returning more or less completely to its normal state and function.

In comparison with this uniform success attendant upon a skilful and persevering management, the result of a method whose object it is to substitute a single cicatrix in place of the whole eczematously-affected surface is no more entitled (as Auspitz remarks) to be called a cure of the eczema than the deep cauterization of a catarrhal mucous membrane, with resulting cicatrization of that structure, can be regarded as a cure of the original complaint.

This criticism is applicable to both of the methods which have been hitherto pursued in the surgical treatment of eczema. In that recommended by H. von Hebra, the affected tissues, in certain forms of the complaint, are removed by the sharp spoon, so as to leave in place of the eczema an ulcerated surface, followed by a cicatrix. In Vidal's process, the same result is brought about by means of multiple and repeated scarification of the eczematous integument. I have made trial of both these methods in one and the same case, with results which were unsatisfactory, both as regards the permanency of the cure and the character of the cicatrix.

Each of these measures, like every other surgical process in the treatment of chronic eczema, can only be employed when the affection is trifling in its extent, and confined to covered parts, *i. e.*, in circumscribed chronic eczemas of the trunk and extremities. In this kind of eczema, when long-lasting, and presumably liable to relapse even after persevering medico-mechanical treatment, a surgical procedure that effects its object in the shortest possible time is fully justified, provided only it be so conducted that the title of a genuine "cure of eczema" cannot be denied to its results. In order to satisfy this requirement, it must consist, not simply in a forcible removal of the diseased surface, the substitution of a sore, and the complete cicatrization of the latter, but, by keeping up the bleeding from the skin as long as possible, it must do away with both the cause and the product of the chronic inflammation.

This much is certain, that every patient will gladly prefer a process of cure which, within two weeks at the farthest, effects the permanent removal of an obstinate and relapsing eczema, and that with but a trifling amount of cicatrization, a process, moreover, involving infinitely less trouble and annoyance than the medico-mechanical treatment.

After numerous experiments in this direction, I have contrived a mode of operation similar in principle to that of Vidal, but effecting its object in a differ-

ent way, which has given excellent results. This I will now proceed to describe.

The affected portions of skin which are to be treated should not be of greater extent than can be completely covered by the hand. After any eczematous crusts which may be adherent to them have been thoroughly removed by warm water or oil, the entire diseased surface is scarified. The scarification is performed with a small, very sharp double-edged lancet, such as is employed by oculists. With this, vertical and horizontal—*i. e.*, rectangularly intersecting—incisions are made, running parallel to each other at intervals of about seven millimetres, and consequently dividing the surface into squares of the same measurement. The incisions must be made pretty deep, their depth in each case depending upon the thickness of the chronic inflammatory products in the cutis. The more compact and harder the affected skin, the more forcibly and deeply must the incisions be carried. The bleeding from them is inconsiderable, and is easily arrested by compresses. When it has been somewhat stanchcd, the whole of the incised surface is covered with a layer of officinal caustic potash. This is well rubbed in with a brush of wadding or of charpie, until the superficial horny layer of the individual skin-squares begins to loosen. The potash is then carefully washed off from the incised places, which are dressed with Hebra's ointment or olive oil. The caustic potash has been rubbed into the incisions, over which it forms, along with the blood, a black eschar extending in straight lines. Previous to the operation, a subcutaneous injection of morphia is administered to the patient, and the affected surface is anesthetized with ether by means of an atomizer.

The dressing of ointment or oil is suffered to remain for twenty-four hours; when it is removed, the little skin-squares are found to be mostly denuded of their superficial epidermic layer. Water-dressing now takes the place of the ointment for another twenty-four hours. When it is removed, the entire eschar is found to have fallen off from the linear scarifications, and in its place are longitudinal sores which encroach on the outlines of the individual skin-squares to the breadth of about one millimetre. In this way the skin-squares themselves have become somewhat smaller, and have lost their rectangular shape, assuming one which is rounder or more irregular; their horny epidermis is entirely removed, and the moist and exuding mucous layer is exposed to view. The portion of skin which has been operated upon now looks like a raw surface, covered with a great number of transplanted pieces of skin, so closely crowded together that the granulations of the sore are scarcely visible between them. Remedies which promote the formation of cuticle, such as solution of nitrate of silver or pyrogallic ointment, are now applied to this surface; these dressings are changed every three days. In from ten to fourteen days, all eroded and ulcerated places are completely skinned over, and the chronic infiltration has partly disappeared, partly is in process of disappearance, entire absorption taking place without further treatment before another fortnight has elapsed. The previously diseased surface now affords an interesting spectacle: The numerous skin-squares are light-red, partially desquamating, and inclosed by linear cicatrices, dark-red, shining, and scarcely one millimetre in breadth. The whole has a reticulated appearance; the fine, dark-colored cicatricial lines surrounding the portions of sound skin with a symmetrical border, like a bright network. The eczema is cured. After several months the appearance just described is altered. The fine cicatricial lines have become white, and the skin-squares have regained their normal color, elasticity, and function. Without noticeable disfigurement, with-

out alteration of its level, without loss of its physical condition or its physiological activity, merely crossed by a number of fine linear cicatrices, the formerly eczematous surface has been restored to health. Here and there, in a very few places only, has one of the little squares of skin been transformed into a fine, delicate cicatricial structure. A trifling amount of scaliness which appears upon these squares after their epidermis is completely restored, is speedily removed by inunctions of oil. The cure so rapidly effected is, moreover, a permanent one. Relapses never occur, even when the eczema thus treated is seated upon the bend of a joint, the operation exerts no influence upon the elasticity and pliability of the skin.

It should be observed that some practice was necessary before I attained complete success in this procedure. In the first case in which I employed it, the incisions were not made deep enough, and the cauterization was not performed with sufficient energy, so that afterwards I was obliged to have recourse to tar, in order to effect a permanent cure. In the second case, I scarified and cauterized too forcibly, and consequently got superficial cicatrices in some places. It was not until the third case that I obtained perfectly satisfactory results.

The cure of a chronic eczema is accomplished by this surgical method in the following manner: 1. The masses of thickened epidermis are removed by the caustic potash. 2. Most of the blood-vessels which supply nourishment to the product of the chronic inflammation in the cutis are severed by the scarification, and to a certain extent destroyed by the caustic potash, in consequence of which it becomes atrophied and is absorbed. In this way the inflammatory product is necessarily caused to disappear from among the skin-squares. 3. In the incisions themselves and their immediate vicinity—*i. e.*, in the periphery of the skins squares—the chronic infiltration is removed by an opposite process, as follows: As a result of the trauma and of the cauterizing, lively inflammation is developed, accompanied by the formation of linear sores; new vessels are produced in the granulations, causing a more active circulation of the blood, by which the infiltration is washed away and disappears. Of course, not *all* the blood-vessels leading to the skin-squares, though certainly the greater part of them, are destroyed by the scarifications, otherwise the absorption of the infiltration would give rise to a single superficial cicatrix, as in Vidal's method. It is possible that, along with the formation of new blood-vessels in connection with the linear sores, new capillaries are also supplied to the bordering, peripheral portions of the skin-squares.

It is thus evident that the designation of "a cure for eczema" cannot be denied to this mode of treatment, since the diseased integument is almost wholly restored to its normal condition, only an exceedingly small portion of it being transformed into cicatricial tissue. This operative procedure accomplishes with more speed and certainty, by a shorter, or, if you please, a more direct route, precisely what is also brought about through a correct and persevering employment of the alkaline spirit of soap, tar, etc.

This surgical method of treating chronic eczema is indicated, as we have already said, solely in cases of circumscribed eczema of the body and of the extremities, with the exception of the hands. It may be resorted to without hesitation in chronic circumscribed eczemas of the bends of the joints, since it involves no risk whatever of lessening their mobility from cicatricial contracture. The superiority of this surgical treatment of eczema becomes more clearly apparent, and is also more correctly estimated by the patient, if the disease is of very long

standing, and especially if it has relapsed frequently, even after skilful medico-mechanical treatment.

I have also employed this method of scarification with advantage in chronic eczema of greater extent, by confining its application to small isolated places where the disease was most pronounced, *i. e.*, where the infiltration was greatest. The following is a case of this kind briefly reported:

M. K. von R., widow, æt. 63 years, had suffered for six years with chronic eczema of the inner surface of both thighs, which had been treated frequently, but without lasting success. The starting-point of the disease was a place as large as the palm of the hand in the middle of the right thigh; here the epidermis and cutis were thickest and reddest. There was a similar spot as large as a five-mark piece on the corresponding locality of the left thigh. May 3, 1884, the former of these patches was scarified and cauterized. The other one, on the left thigh, was not scarified, but merely softened with potash. The remaining portions of the affected integument were then treated with spirit of soap and Hebra's ointment, afterward with white precipitate ointment and tar. May 14, 1884, the scarified place on the right thigh is cured. June 20, the disease has disappeared everywhere else excepting from the spot on the left thigh, which is still scaly and infiltrated. In the beginning of July this too was well. In September, a relapse occurred in this latter situation in the form of a papulo-squamous eruption of which at first the patient took little notice. At the end of September, the renewed infiltration having made considerable progress, the seat of relapse was scarified and cauterized. Complete recovery took place in ten days, since which time there has been no return of the complaint.

In two other cases besides this, of non-circumscribed chronic eczema, I have scarified small places that were the most infiltrated, with the same favorable result. One was a case of chronic eczema of the dorsa of both hands, the other of chronic eczema of both nates. These partial scarifications shortened the duration of the whole treatment, and increased the probability of a permanent cure. —MAX BOCKHART, *Deutsche Med. Wochenschrift*, July 16, 1885.

ON SYPHILITIC STRICTURE OF THE TRACHEA.

SYPHILITIC affections of the trachea may be classed amongst the rarer forms of syphilis. They may occur both in congenital and acquired syphilis, and in the latter may be observed both in the earlier and later stages of syphilis. In the earlier stage of syphilis we meet chiefly with tracheitis, condylomata, and mucous plaques. These affections give rise to no grave symptoms, and yield soon to treatment. The lesions which are found associated with the later stages of syphilis are, however, much more serious, and often lead to death. These lesions are either gummous tumors or, much more commonly, syphilitic ulcers with surrounding infiltration, which by their cicatrization lead to stenosis of the trachea; or, by an extension of the ulceration, there may be perichondritis, necrosis of the cartilage rings of the trachea, with contraction and displacement of the trachea or perforation of the tracheal wall, with abscess formation in the mediastinum; or again, especially if the ulcer is situated in or near the bifurcation and involves also the large bronchi, there may be rupture into the pulmonary artery (Gerhardt, *Deutsches Arch. f. klin. Med.*, Vol. II., p. 541; Kelly, *Trans. of Path. Soc.*, Vol. XXIII., p. 45); or into the arch of aorta (Wilks, *Trans. of Path. Soc.*, XVI., p. 52). In most cases, however, death has resulted suddenly after the symptoms of tracheo-stenosis had existed for some time.

The symptoms produced by syphilitic disease of the trachea vary with the situation and extent of the ulcerations, and with the presence of syphilitic disease in other portions of the respiratory tract, especially in the larynx. In an analysis by Vierling (*Deutsches Arch. f. klin. Med.*, XXI., p. 325) there was an affection of the larynx in thirty out of forty-six cases reported; in sixteen the trachea, with or without the bronchi, was found affected; while in five the bronchial mucous membrane was the only part attacked.

The diagnosis of tracheal syphilis presents no difficulty when the larynx is also affected, and when there are other syphilitic symptoms. If, however, the trachea alone, or the trachea and the bronchi are affected, the symptoms are those of stenosis, and the differential diagnosis between syphilis of the trachea and some mechanical compression of the trachea, either from an enlarged gland, a small intra-thoracic tumor, or an aneurism of the arch of the aorta is not always easy.

The most prominent symptoms of tracheal stenosis are :—

- 1. Dyspnœa, most marked during inspiration, and especially so on any exertion of the patient. This, though a most prominent symptom, may occasionally be absent, though the obstruction to the entrance of air into the lungs may be very great, as in a case reported by Beger (*Deutsches Arch. f. klin. Med.*, Vol. XXIII., p. 608), where there was most marked narrowing of the bifurcation and of the bronchi by a gummous tumor.
2. A hoarse, weak, or croupy voice, even if the larynx be free from disease, due to the weak air current.
3. Swelling of the jugulars with every expiration, due to the abnormally increased pressure in the large veins within the thorax during expiration.
4. Slight downward movement of the larynx with every inspiration. This movement is much more considerable in stenosis of the larynx (Gerhardt).
5. The patient breathes easier with his chin depressed, as this causes relaxation and dilatation of the trachea. In laryngeal stenosis, on the other hand, the head is thrown back to facilitate the breathing (Gerhardt).
- 6. Retraction of the lower part of chest with every inspiration.
7. Loud inspiratory stridor, heard best over the sternum, occasionally accompanied by a thrill, to be distinctly felt over the place of constriction. Auscultation of the lungs reveals weak breathing and loud rhonchi, unless here be some lung complication. It often happens that the stricture is at the bifurcation of the trachea, and extends to one bronchus rather than to both. In such cases we have the characteristic symptoms of stricture of a bronchus (diminished fremitus, diminished breathing, and more marked inspiratory retraction of the ribs) on that side.
8. The laryngoscopic examination may enable us to see the affected part, especially if the stricture is high up in the trachea or if the ulceration is extensive; and the introduction of sound through the larynx, recommended first by Demme, *Wien. med. Zeitschrift*, 1861, p. 441, may, in doubtful cases, assist us in our diagnosis. In spite of these definite symptoms, the diagnosis between syphilitic stricture of and pressure on the trachea is sometimes a matter of great difficulty.

Treatment.—I would suggest in such cases the gradual dilatation of the constricted part or parts. This could be done either through the larynx—and, according to several observers, a sound may easily be passed between the vocal cords into the trachea without much distress to a patient—or, better still, directly through the trachea, after having previously performed tracheotomy. This mechanical treatment should be combined with an anti-syphilitic treatment to check the further

extension of the ulceration, and to prevent the further troubles, such as necrosis of cartilages, abscess formation, etc., only such treatment should not be too energetic, so as not to cause a too rapid cicatrization, for the slower the narrowing of the lumen takes place, the more likely will there be a gradual accommodation of the lung to the altered condition.—DRESCHFELD, *Medical Chronicle*, Dec., 1885.

OBSERVATIONS ON ECZEMA.

DELIGNY defines the anatomical lesion in eczema as an epidermo-dermatitis of a special nature. It is not an inflammatory lesion, such as can be produced artificially by irritation of the skin. It is a special inflammation, for it has a special evolution, at one time a moist, at another a dry catarrh, facts not observed in artificial dermatitis. This is an important point which is not admitted by the German school, but which can be deduced from clinical observation. Speaking of the causes of eczema, he says: Diabetes not only produces a genital eczema, but also eczema of other parts of the body; in fact, the skin acts badly in diabetic subjects, it is habitually dry, perspirations are rare, and when they do occur, they eliminate a certain quantity of sugar, an incessant cause of irritation for the integument. At one time this results in a pruritus, one of an intense character, and generalized, to which attention has been called by Hebra, Garrod, and Siegen. At another time it leads to erythema, lichen, and eczema. On the diagnosis between eczema of the scalp and pityriasis, he observes: Many persons exhibit permanently, from the age of 10, 15, or 20 onwards, a desquamation of the scalp which they and certain physicians regard as a pityriasis of the scalp. Most frequently it is not so, but an abortive eczema. That which is a pityriasis of the scalp is a desquamation consecutive to a seborrhœa there, under the form of fine grayish-white micacious scales, resembling bran, which causes falling off of the hair. Eczema may persist on the scalp for years without implicating the hair; and this eczema of the scalp, which we may call like pityriasis (in giving to the word pityriasis a precise signification), does not cause baldness. This is an important distinction, and one which, unless borne in mind, may lead to inconveniences from the treatment adopted. Most frequently, indeed, the affected person intrusts himself to the care of his hairdresser. This is of no moment if he has a seborrhœa, as cleanliness is always useful in that; but if he has eczema, it becomes worse under such treatment. Amedie Latour has related in the *Union Médicale* the harm done to his scalp in such circumstances. Borax is the best application in scaly eczema of the scalp, not only in cleansing the head, but in arresting the desquamation. Michle recommends:

R Boracis. grs. 150.
Alcoholis,
Aq. Rosæ..... āā ʒ iv.

Boracic vaseline is an excellent preparation which is often employed at St Louis.

R Acid Boracic. pulv..... ʒ iss.
Vasellini..... ʒ i.
Bals. Peruv..... grs. viij.

The tincture of benzoin and the balsam of Peru are used in virtue of their stimulant action. Enveloping the parts in india-rubber coverings renders great service in all crusted eczemas, above all in eczema of hairy parts. It is econom-

ical, and replaces poultices in extensive eczemas. The direct contact of the sheet of india-rubber with the skin, and particularly with the diseased surface, is not always well borne by every one. Besnier, therefore, modifies it as follows: He dips bands of muslin in starch water, prepared by adding a teaspoonful of starch to a quart of water. He surrounds or covers the affected part with two or three folds of thin muslin, above this he puts the india-rubber sheeting. If the secretion is fetid, he adds to the starch water boracic acid in the proportion of 75 grains to the quart. When all inflammation has disappeared, he recommends to add 1 grain per 1,000 of sulphate of copper, to hasten the cure. Sulphate of copper is little used in dermatology, and this is a mistake, since its use is the cause of nearly all the success of the quacks who treat skin diseases. One per thousand in solution causes no inflammation. Prolonged rest in bed is in some cases a useful adjunct in the treatment of eczema. The recumbent position may be maintained for fifteen to eighteen hours out of the twenty-four. It is particularly serviceable in eczema of the limbs, where walking and fatigue might aggravate the inflammation, and it is useful, also, in very extensive eczemas.—*L'Eczema* (par Dr. L. Deligny), Paris, 1885. *Ed. Med. Journal*, Nov., 1885.

THE LOCAL TREATMENT OF PSORIASIS BY CHRYSOPHANIC ACID.

IN only one instance among the seventeen cases cited in this essay—making allowance, that is, for intervals of time during which the frictions were suspended, owing either to a failure in the supply of drugs or to the supervention of conjunctivitis—was treatment continued longer than a month; with many patients it lasted only half that time, and some required but four or five applications.

The single case which proved refractory remained, it is true, a long time in the hospital, but this was because he was six weeks in another service, which he left uncured; moreover, a fresh outbreak of the disease took place under our own observation, upon the very locality of the first attack.

That the remedy under consideration has not the property of preventing relapses is proved by the fact we have already mentioned, that it is only adapted to remove the existing cutaneous symptoms, and hence in cases of psoriasis, which may be denominated a perpetual disease, the struggle will sometimes have to be maintained indefinitely, if we would not leave the malady to conquer in the end.

This want of power to prevent a return of the complaint is clearly displayed by several of the cases above referred to, in which, after all the psoriasis-patches had disappeared, new papules were seen to arise.

Our most speedy cures have been effected among out-door patients in regular attendance, these being less severely affected than the hospital subjects.

Our treatment of psoriasis does not consist wholly in the application of medicated plasters. These may be sufficient for mild cases; in those of a different character we have the patient take a bath of starch every two or three days, either at the commencement of his treatment or throughout its continuance. This is of service by promoting the detachment of the more superficial psoriasis-crusts, and thus facilitating the action of the medicine; subsequently also it has the effect of subduing the erythematous inflammation in the neighborhood of the patches. Moreover, when the disease is extensively diffused, we confine our applications to a single portion of the surface, in order to test the patient's susceptibility to the drug, before rubbing it in all over him. From the latter process no unfavorable constitutional results are to be apprehended, because, 1st, chrysophanic acid is

not poisonous, and, 2d, it is not absorbed. Microscopical examination has failed to detect it in the urine; nor has this secretion, in the case of our patients generally, yielded the slightest trace either of chrysophanic acid or of albumin. The treatment we are describing may therefore be regarded as absolutely harmless.

On comparing the average periods of time required for the cure of psoriasis, as laid down by the authorities, we find that the arsenic treatment takes three or four months; that by oil of cade, from six to eight weeks; pyrogallic acid, four or five weeks; while chrysophanic acid does its work in a fortnight or three weeks—at farthest, in a month.

Relying upon these considerations, we have not the slightest hesitation in assigning to chrysophanic acid, employed in the form of plasters, the foremost place among the local remedies for psoriasis.—A. DÉROBERT, *Thèse de Paris*, 1884.

XERODERMA PIGMENTOSUM.

PROF. KAPOSI presented before the Society of Physicians, of Vienna, at the meeting of October 23d, 1885, the case of a girl aged 9 years, affected with xeroderma pigmentosum. In the region of the face, the nose, and the eyelids, were present multiple carcinoma nodes and warty formations, in a favorable condition to be transformed into epithelial cancer.

Kaposi first described the nature of this disease in 1870. It is met with in early life, beginning as a rule at the end of the first year or during the second year of childhood.

There usually appear upon the face, the backs of the hands, and upon the palms, smooth pigment spots of either a light or dark-brown color, resembling lentigo or freckles. These spots in later years spread over the region of the neck, arm, forearm, back of foot and leg, in greater number and wider distribution.

The process first assumes the features of a separate and distinct disease when atrophy begins. Small white spots are now noticed which are free from pigment, smooth, and like cicatricial tissue, covered with thin wrinkled epidermis. The skin now becomes decidedly thinner, parchment-like and shrunken, so that the nose appears pinched and shortened, and the openings of the eye, the nostrils and the mouth, seem contracted. Finally, multiple carcinoma and often sarcoma, and malignant papilloma appear, and in many cases this complication has been the cause of death.

Up to the present time, thirty-eight cases of this disease have been published. These are collected and tabulated by Prof. Kaposi.

The table shows that several children of a family are, as a rule affected, and with two exceptions those observed up to the present time have been children of the same sex in each family. The youngest patient was five months, and the oldest forty years of age. The sex was about evenly divided; there being twenty females and eighteen males. The largest series of observations in one family is reported by Rüder, who saw seven brothers thus affected. The other cases are mostly in groups of two or three brothers or sisters. It is much to be desired that the relationship between melanosis and multiple carcinoma and sarcoma be arrived at.—*Wiener Medizinische Wochenschrift*, No. 44, 1885.

CHROMIDROSIS OR CHROMOCRINIA.

At a recent meeting of the Academy of Medicine of Paris, Dr. Féréol communicated an observation of Labourdin, an accomplished pathologist, on a case of chromidrosis, or, as he prefers to call it, chromocrinia.

The observation was verified by Dr. Féréol himself and Dr. Rochard.

The subject was a young woman, of about twenty years of age, who suffered at times from violent attacks of convulsive hysteria, and from neuralgia. In February last, a blue discoloration was first noticed on the lower eyelids. At first it was not very intense, and varied from day to day. It became very marked under any nervous excitement, and merely speaking of it to the patient would suffice to bring it out.

The same discoloration was found over the sternum, in the inter-mammary region, and in both axillæ. There was scarcely a trace of perspiration. The possibility of fraud was excluded, and the patient greatly desired relief. Microscopic examination of the coloring-matter showed all the peculiarities described by Ordoñez. The fragments of coloring-matter closely resembled the scales resulting from the fracture of dried Canada balsam.

Dr. Féréol insists on the absence of sweat in nearly all cases of observed chromidrosis, and thinks it would be justifiable to use the name *chromocrinia*.

Three cases of *yellow chromidrosis* were reported by Dr. Tison at the Paris Academy of Medicine, in December, 1884.

Three servants in the same family were affected at the same time with a bright yellow discoloration of the neck, back, and chest, sharply defined. The coloring-matter was secreted more abundantly when perspiration was free, and continued to appear for two and a half months.

No cause for simulating could be found.

There was no sign of jaundice.

Dr. Méhu held that the material consisted of sulphur, but this point was not definitely settled. Occurring as it did in three men in the same house, it would appear as though due to some common external cause, and not the disease usually seen in hysterical women.—*Bulletin de l'Acad. de Médecine*.

TREATMENT OF THE SCROFULOUS DIATHESIS.

FOR the treatment of the scrofulous diathesis, M. Guibout particularly recommends the use of iodine, either in the form of iodide of starch, giving ten to fifteen grams a day, or as iodide of potassium, with or without the addition of the tincture of iodine. A favorite prescription with him is:

R. Mucilag. gum. acaciæ	150 grams.
Potass. iodidi.....	2 “
Tinct. iodini.....	10 to 15 drops.
Tannin....	1 gram.
Syr. of cinchona.....	30 grams.

M. Sig. To be taken in three doses during the day.

With the iodine, it is best to make use of cod-liver oil, iron, cinchona, mineral waters, and strong wines. The patient is to be put in the best hygienic surroundings, such as fresh air by the seashore, the use of baths, gymnastics, rich, nourishing animal diet, and frictions of the skin. If the appetite or digestion becomes sluggish, it is to be stimulated by bitter stomachics before meals, and by saline purgatives from time to time.

For the destruction of scrofulides (such as lupus), one of three plans may be adopted: 1. Apply to the diseased patch an ointment composed of fifteen grammes of the biniodide of mercury and thirty grammes of fresh lard, to be left on for twenty-four hours. This will produce a pustular eruption. In time, with

successive renewals of the ointment, the scrofulide will be destroyed. 2. Multiple punctures or scarifications. 3. The thermo-cautery, using the Paquelin.—*Gazette Médical des Hôpitaux*, No. 79, 1885.

TREATMENT OF ECZEMA.

FOR the treatment of eczema, M. Guibout recommends in localized acute eczema poultices of potato starch made quite moist, applied almost cold, and renewed three times in twenty-four hours; lukewarm bran or starch baths; lukewarm lotions; avoidance of all local irritation and friction. When eczema attacks the scalp, he orders the hair to be cut off (a generally unjustifiable proceeding, in my judgment, and to be especially avoided in women). When the face is attacked, he covers it with a mask of potato starch or of vulcanized rubber, leaving apertures for nose, mouth, and eyes. If the disease appears on the genital region, he insists upon the horizontal position being preserved by the patient, and when it attacks the legs, they must be kept elevated, and never allowed to hang. When the eczema is universal, vulcanized rubber garments are to be worn constantly, and changed every twenty-four hours. If these cannot be had, white-wash the body with a mixture of equal parts of oil of sweet almonds and lime water, and powder the surface with starch. With this, a bath of bran water is to be taken every day, or second or third day.

In chronic eczema, more stimulation is needed, such as sulphur vapor baths, alkaline baths, smearing the part with oil of cade, frictions with green soap, lotions of bichloride of mercury, one part in five hundred of dilute alcohol, or an ointment of boracic acid, ten grams, in vaseline, one hundred grams.—*Gazette Méd. des Hôpitaux*, No. 85, 1885.

CONTAGIOUSNESS OF VARIOLA AT THE BEGINNING OF THE ERUPTION.

LANCEREAUX reports three cases occurring in his hospital service, in which small-pox was transmitted at the beginning of the eruption. From these facts he draws the conclusion that variola may transmit itself on the first or at least the second day of the eruption, since the small-pox patient admitted by mistake in the hospital was transferred two days after the appearance of the eruption. This is, however, not the opinion commonly admitted. An English physician of great celebrity, Herberden, following the citation of Dezateux and Valentine, asserted that he was in possession of facts demonstrating that small-pox could not be communicated until after the second or third day of the eruption, and that persons who had never had it might, up to this period, sleep with those who had it without risk of taking it.—*Bul. de l'Académie de Médecine*, Sept., 1885.

PERFORATING ULCER OF THE HAND.

AT a recent meeting of the Surgical Society of Paris, M. Terillon presented a mould of a case of perforating ulcer of the hands. The disease was similar in every way to the perforating disease of the foot.

Healing rapidly took place when the hands were not used, but when the patient returned to work the ulceration began again. The subject was a male, 25 years of age, syphilitic and tabetic. All the symptoms of locomotor ataxia were present, and there was complete anæsthesia about the ulcerations. A central trophic lesion of the upper part of the spinal cord was suspected.

M. Terillon had presented a similar case at a previous meeting.

M. Trélat stated that he had seen the ulcers upon the hands and feet at the same time, in a patient who was ataxic.—*Revue Médicale*.

THE TREATMENT OF LUPUS BY ARSENIC.

To discover just what influence the internal administration by arsenic without any local therapy whatever has upon the evolution of lupus, Lesser (*Centralblatt für die Med. Wissensch.* No. 7, 1885) administered it in five cases. He used in his observations Asiatic pills, and at times subcutaneous injections of Fowler's solution.

In one case there was no beneficial result, but in the other four a decided improvement followed. The infiltrations became levelled down, and the author testified in his conclusions that the drug exercises a decided influence on the resorption of lupus infiltrations, although probably not under all conditions, and possibly it is not to be hoped that entire healing will take place under its administration. It is to be noted that the drug was given in large doses and for a considerable length of time.

DRESSING OF CONTUSED WOUNDS WITH DECOCTION OF VALE- RIAN ROOT.

DR. ARRAGON has recently communicated to the Société de Biologie the results of his treatment of contused wounds with the following preparation :

℞ Rad. Valerianæ..... 30 grams.

Aq. 1 litre.

Boil for half an hour, strain, and apply over the wound compresses soaked with this decoction. Keep the compresses constantly moist. M. Arragon reports nearly fifty cases in which this treatment was satisfactory. The cure is not more rapid than with ordinary dressings, but the remarkable fact is that the symptom of pain is entirely annihilated. This is probably due to the action of valerianic acid upon the terminal filaments of the nerves.—*Journal de Médecine et de Chirurg.*, Oct., 1885.

ABORTION OF SMALL-POX.

REIMER who has had a large experience in the treatment of small-pox, strongly recommends as the best means of aborting commencing pocks, the use of Schwimmer's salve, composed as follows :

℞ Acidi Carbolici.....grs. 30 to 80

Ol. Olivarum 3 v.

Cretæ pulv. 3 i.

M.

It may be applied on linen to any or all of the affected places and changed twice daily. In not one case in which it was applied was the suppuration well marked, and only seldom were slight scars formed on the nose. The method is not applicable to young children, both on account of the difficulty of retaining the bandages in place, and of the liability to carbolic acid intoxication. Acting on a suggestion of Clavidge, Reimer administered sodium salicylate in 5-10 gr. doses day and night in fourteen cases, and found in every case, even on the second day, a distinct arrest of development of the pustules. They remained flat and quickly dried up from the centre.—*St. Petersb. Med. Woch.*; *Med. Chronicle*, Sept., 1885.

Items.

TREATMENT OF PSORIASIS.—In psoriasis, Dr. Guibout prefers the oil of cade, having it well rubbed in, and ordering soda baths every day or so, this treatment to be continued until the pigmentation due to the disease has disappeared. If, for any reason, he cannot use the oil of cade, he employs a five to fifteen per cent pyrogallic-acid ointment, having it applied twice a day, and directing the patient to take a daily bath.—*Gazette des Hôpitaux*, No. 88, 1885.

THE PRURITUS OF DIABETES.—Dr. Blanchet, of Vichy, recommends in the treatment of this distressing complication of diabetes the use of alkaline sitz-baths for sixty minutes at a time, followed by lotions of glycerin. He has had good results from the use of an ointment composed of the oxide of zinc, twenty-five grams; salicylic acid, one gram; and glycerole of starch, twenty-five grams.—*Gazette des Hôpitaux*, September 22, 1885, p. 868.

DIAGNOSIS OF GONORRHOEA IN THE FEMALE.—Dr. Martineau claims that a specific may be distinguished from a simple vaginal discharge by the simple expedient of using a piece of litmus paper. In the specific form the reaction is always acid, while in the simple form it is always alkaline. The same test is also of value in cases of rape in deciding whether the person who committed the crime was then suffering from gonorrhœa, as the vaginal discharge proceeding from this cause would be acid.

MICROCOCCI OF ALOPECIA AREATA.—At a late meeting of the Society of the German "*Naturforscher und Aerzte*," Professor von Sehlen called attention to the fact of his having made cultures of characteristic micro-organisms taken from a typical case of alopecia areata. He eliminated all sources of doubt arising from a possible mistake of the disease for herpes tonsurans, and maintained that the existence of these cocci is both constant and pathognomonic of the disease.

TREATMENT OF FRECKLES WITH CARBOLIC ACID.—Dr. Hal-kin's procedure is as follows: The skin being washed and dried, is put on the stretch with two fingers of the left hand, and a drop of pure carbolic acid is applied exactly over the patch. When it dries the operation is completed. The skin becomes white, and the slight sensation of burning disappears in a few minutes. The thin crust which forms after the cauterization should not be disturbed; it detaches itself spontaneously in eight or ten days, leaving a rosy coloration, which is soon replaced by the normal color of the skin.

QUININE IN SKIN AFFECTIONS.—In the *Monatshefte f. Prakt. Derm.* Hager calls attention to the great value of quinine and its derivatives, both externally and internally, in skin affections. Sub-ungual whitlow he has always been able to cure readily in two to three days, by using a water-bath and administering pills of sulphate of cinchonidine in dose of two and a half grains hourly the first day, and less frequently afterward. In a highly inflamed varicose leg with oozing eczema, quinine reduced the inflammation so that the patient could walk within a week, and had no relapse. In facial erysipelas, and in a number of acute local surgical affections, he has been equally successful.—*Med. Chronicle*, Nov., 1885.

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ON THE LIMITATION OF THE CONTAGIOUS STAGE OF SYPHILIS,
ESPECIALLY IN ITS RELATIONS TO MARRIAGE.¹

BY

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IN seeking to establish the limit of the contagious stage of syphilis it is important to appreciate what has up to the present time been determined in regard to the nature of the contagium of syphilis. The microscopic investigation of Burdon Sanderson, Beale, and Chauveau resulted, a quarter of a century ago, in the discovery of the disease germs of variola, vaccinia, the cattle plague, and relapsing fever.

It was then demonstrated that a living germinal cell was the starting-point of those diseases in each case. Beale, besides this, claimed that another germinal cell with properties and powers identical with those of the human white blood-corpuscle was the starting-point in syphilis, and he also claimed that this cell was directly descended from degraded cell elements of human origin. It was represented as varying in size, from that of the normal white corpuscle, in proportion to the degree of its degradation, from 1-3,000th to 1-100,000th of an inch, or even less in diameter.

With nothing in its composition or in its physical proportions to distinguish it from the nuclei or the nucleoli of the normal white blood-corpuscle, hence with nothing but its morbid activity, its increased capacity for proliferation, to distinguish it from the normal cell element, it is not surprising that Beale should have failed to demonstrate his theory

¹ Read at the Annual Meeting of the New York State Medical Society, Feb. 5, 1886.

through microscopic investigations. Alfred von Biesiadecki, of Krakow, however, in 1867 discovered a marked proliferation *in loco* of apparently normal cell elements at the site of the syphilitic inoculation, progressing chiefly, if not solely, in the line of the lymph channel, and accumulating in a characteristic way in the lymphatic glands in connection with them, and he claimed this as an evidence that it was through the lymph channels alone that the syphilitic infection invaded the organism.

Cohn soon after showed also, through extensive microscopic researches, that the papules of the active or so-called secondary stage of syphilis were caused by an accumulation of germinal cells, similar to those demonstrated by Biesiadecki in the initial lesion of syphilis and in the adjacent lymph channels and glands, and that the mucous patches and tubercles and the alopecia of syphilis were caused by a similar localized accumulation of cells, proliferated through the syphilitic influence. Other competent observers confirmed these discoveries, and the investigation was pushed forward, notably by M. Cornil, of Paris, until it was shown that every lesion and manifestation of the active or so-called secondary stage of syphilis was characterized by the same aggregation of the newly-formed cells possessing the contagious property of syphilis, but free from any other distinctive quality except so far as it might result from the greater tendency of new formation to break down into pus, or from the mechanical pressure caused by the accumulation.

The contagious property of these cells, their power to communicate syphilis through contact with an abraded surface in an otherwise healthy organism, required explanation before the degraded white blood-cell or disease germ of Beale could be accepted as the true contagium of syphilis. Rindfleisch, in 1870, called attention to a fact observed by him that the normal germinal cells exert an influence upon one another through contact. He says: "The opinion is inevitable that the embryonal formative cell can only become an epithelial cell when it comes in contact with such; we must believe in a kind of epithelial infection." If, then, infection of cells by other cells is accepted as a physiological process, certainly the power of a degraded white blood-cell to accelerate proliferation in normal cells with which they may come into contact may be accepted; and we then have in the degraded white blood-corpuscle of Beale all the necessary attributes to figure effectively as the true contagium of syphilis.¹

Through its acceptance as such, I think it can be shown that we have a clue which will lead us to a reasonable explanation of every stage and

¹This view of the case does not preclude the idea of a possible specific micrococcus which penetrates the germinal cells, may then become the cause of infection in the same manner as the disease germ of Beale, but until this micrococcus is absolutely demonstrated, we may reasonably accept the possibilities in favor of the degraded white blood-cell.

lesion of syphilis—an explanation in full harmony with all known physiological and pathological laws. Through it we are led to the adoption of a course of treatment which, while still in accord with the results of clinical experience, is no longer empirical. On the other hand, for now more than twenty years microscopists all over the world have been diligently searching for the syphilitic entity or virus, but without success, although its alleged discovery has been announced with great publicity and positiveness from time to time. First it was a minute and peculiar vegetable spore (Salisbury), but this, through more extended investigation, was found unessential to the development of syphilis. It has been displayed to continental scientists as a peculiar property (Lorstorfer), and was accepted for a brief period as the veritable contagium of syphilis; but this was soon proved to be but the simple outcome of various forms of cachexia. Then a rod-shaped micrococcus (Klebs) was brought forward, and claimed to be capable of producing lesions resembling those of late syphilis, but this too proved a failure.

More recently, within the past year, it was announced that Dr. Lustgarten, of Vienna, had at last discovered the true virus of syphilis in a characteristic bacillus which he described with great exactness and circumstantiality. Within a few months, however, investigations touching the validity of this discovery were set on foot by M. Cornil, of Paris, when it was soon determined that Lustgarten's discovery must be relegated to the list of previous failures. The bacillus in question, while found frequently associated with syphilitic lesions, was not confined to them, but was found in the secretions about the prepuce, the pendulum, and the anus in persons not syphilitic.

It will thus be seen that the disease germ of Beale is the only one now in the field which demands consideration as the contagium of syphilis, and it will be my effort to-day to point out the important relations in which it may be claimed to stand with the acknowledged mysteries and disputed doctrinal points of syphilis, especially as affording us much needed assistance in studying the limitations of the contagious stage of the disease.

Although not strictly germane to our subject, permit me, in the first place, to call your attention to the important fact that it is through recognition of the proliferation of cell elements, as a characteristic feature of the initial lesion of syphilis, that we are enabled to set at once and finally at rest the long disputed point as to the unity and duality of syphilis. Through this view it is seen that syphilis is a disease essentially of growth, destruction of tissue occurring only as the result of overgrowth, through which the vessels of nutrition of the part are obstructed; while in chancre the process is a destructive one *per se*. Syphilis may, and not infrequently does, go through all its stages in a characteristic man-

ner without a single breach of tissue, while Chancroid is always and only a process of destruction of tissue.

In whatever consists the true contagium of syphilis, one important fact in relation to it is well proven, namely, that it is contained in the substance of the initial lesion or chancre, and the lymph channels and glands in immediate relation thereto, and that, as a rule, for a period of at least eight weeks, it is confined between this point and the general blood current.

It will thus be seen that the doctrine of a mysterious instantaneous syphilitic infection, as still claimed by some authorities, is denied, and that a gradual infection, through physiological channels, alone can be considered possible.

A few words in proof of this position : Inoculation of healthy persons with the blood of a person affected with an initial lesion of syphilis failed to communicate syphilis until after the eighth week from the date of infection. Several well authenticated cases of this sort have come to my knowledge. Twice the inoculation was in my own person. A great amount of evidence on this point is furnished by Diday. In his work on infantile syphilis, Diday says that syphilis, contracted by the mother, after the seventh month of gestation, has never produced the disease in the fœtus. Abernethy had previously claimed the same immunity for the fœtus after the seventh month, but Diday asserted it as a *law* to which there were practically no exceptions. On page 32 of his work on "Infantile Syphilis," Sydenham edition, 1859, he says : "Under similar circumstances, a child born apparently healthy of a woman, who had contracted syphilis in the eighth or ninth month only, might be entrusted to a nurse without fear of communicating the disease to her."

Practically, then, it is thus shown that the disease, being limited to the initial lesion and its immediate vicinity, during the first two months after infection, syphilis may, up to such period, be claimed as a local and not a constitutional disease.

It has been proven and accepted by such authority as Fournier and Cornil, of Paris ; Mireur, of Marseilles ; Van Buren and Keys, and Bumstead and Taylor, of New York ; Hill and Cooper, of London, and others, that the physiological secretions, mucus, milk, tears, sweat, sebum, urine, semen, etc., do not contain the contagium of syphilis.

A consideration of this important fact enables us to eliminate from the mysteries of syphilitic contagion, such cases as those where the father is claimed to have infected the embryo or fœtus, while the mother escaped the disease, and also makes it clear, beyond dispute, that syphilis is never, under any conceivable circumstances, communicated from the father directly to the fœtus, but that, in order to infect the product of conception before birth, the mother must first be infected ; the semen having been

proven not to contain the contagium of syphilis, settles this much-discussed question, inasmuch as, through the semen alone, has the father any possible access to the ovum or the fœtus.

It will also be seen that, if the physiological secretions, which do not contain germinal cells, are free from the contagium of syphilis, this constitutes a strong argument in favor of the nature of the contagium of syphilis, as claimed; and further, if contact of a degraded germinal cell, is essential to the production of syphilis, and the disease is conveyed to the embryo or fœtus, only through the blood of the mother, there is no longer, strictly speaking, any hereditary transmission of syphilis. In order to the acquirement of syphilis, an organism free from that disease is essential. The infecting cell of syphilis, must first be brought in contact with otherwise healthy cell material. "No mysterious hereditary influence is necessary, nor can be admitted. If the disease germ of syphilis, by contact with external parts, or through its amœboid power traversing tissue, reaches healthy cell material, whether in the adult, the infant, or the embryo, then the syphilitic influence is *directly transmitted*, and its development must be governed by the same laws that characterize its progress in the known behavior of the disease in the adult, modified, to a greater or less extent, by the age and degree of stability of the tissues involved. It is true that various adynamic conditions in foetal and infantile life, result from pre-existing disease in the generative organs of parents who have been subjects of syphilis; but that any syphilitic disease, proven to be such by its power to transmit syphilis, has been communicated to healthy persons, after the action or so-called secondary stage of the disease has passed, there is no well-authenticated evidence to prove."

I am quite aware that this position will at first be received with surprise, but it is the logical sequence of the acceptance of the degraded human germinal cell as the true contagium of syphilis, and it can, I believe, be shown to be in the fullest accord with all well authenticated facts in regard to hereditary syphilis.

These views were originally published by me, in a series of class-room lessons, in 1879, and again in my volume on the Physiological Pathology of Syphilis, in 1881, and elaborated more fully in an article on the syphilis of infants and hereditary syphilis, in 1884. It is worthy of remark that Mr. Jonathan Hutchinson, of London, a leading authority on syphilis in Great Britain, has arrived at conclusions identical with my own, in regard to the nature of the so-called Hereditary Syphilis. Thus, in his "Pedigree of Disease," published in London, 1884, page 90, he says: "A child then, I assert, inherits syphilis in precisely the same sense and in precisely the same manner as it may inherit small-pox. It inherits, not *the diathesis, but the disease*. The reason why the inheritance

of small-pox is rare, while that of syphilis unfortunately is common, is simply that the period during which the virus is extant, in the blood, is very different in the two cases. The conspicuous facts, then, in reference to the syphilis of infants, afford no proof that the diathesis of syphilis, any more than those of the other exanthemata, is capable of transmission." Mr. Hutchinson further says: "My argument, if I have made it plain, has pointed to the conclusion, that, no *minified* transmission of syphilis is possible, and that the child gets, either nothing at all, or the germs of the disease, and that in the latter case they will, subject to the laws of idiosyncrasy, develop equally in all cases."

Having thus indicated the limitation of the contagious element of syphilis in the matter and mode of infection, we have now reached a point where we may, I think, proceed to the consideration of the probable, or possible, limit of the contagious stage of syphilis, in point of time. A very general impression prevails, both in and out of the profession, that syphilis is capable of being communicated to healthy persons, by a person, once the subject of the disease, either by contact or by heredity, throughout the lifetime of the individual. It is a common belief that, when, after years of freedom from any evidence of the disease, any lesion is recognized as due to a former syphilis, it is an evidence of a poison still remaining in the blood of the individual, and that it may be transmitted to a healthy person by contact or by heredity. It has, however, now come to be understood, practically, that when the accumulations of cell material, which have caused the lesions of the secondary stage, and the enlargement of the lymphatic glands at various points, have been eliminated, the disease is, as a rule, no longer contagious, and persons, the subjects of syphilis, who have, by systematic and thorough treatment, been brought to this condition, are said to be cured of syphilis. The time during which the treatment is recommended, by authors, to be continued, is pretty uniformly fixed at about three years. If then, the patient has been free from all signs of syphilis for one year, he is pronounced cured, and he is permitted to marry.

Fournier says: "The truth is that, with some very rare exceptions, syphilis constitutes only a temporary bar to marriage." Bumstead and Taylor say: (5th Edition, page 91) "It may be stated in broad terms that no syphilitic father should procreate children until two years after infection, during which he should sedulously follow a systematic course of treatment." Keyes (Venereal Diseases, Wood & Co., 1880) says: "After the virulence of the disease has been exhausted, a man may marry, and should marry." Again, page 78, *ibid.*, "In a general way it it may be safely said that a man should not marry until at least three
ood years lie between him and his chancre, and at least one year has elapsed since the last symptom which can be ascribed to syphilis." Hill

and Cooper (London, 1881): "Under any circumstances, the shortest period between infection and marriage should be three years. . . . Under no circumstances should a person with obvious signs of syphilitic disease marry, however long a time has elapsed since his infection, for, though communication is rare when several years (four or five) have elapsed, *it may still take place after as many as ten or even more years, even when the form of disease is of the character commonly called tertiary.*"

It will thus be seen that authors are not quite harmonious in regard to the safety of marriage after syphilis, although all are agreed that no marriage should be permitted until a year after the disappearance of any lesion which could be attributed to syphilis. All, however, are agreed, that the communication of syphilis, after the third year of its existence is rare. It has, however, been determined, by careful clinical observation, that the contagious element of syphilis, is, as a rule, eliminated within a period varying from perhaps two to four years, and that all the manifestations of disease beyond this time, and apparently due to syphilis, called tertiary lesions, are not entitled to be considered, strictly speaking, as syphilitic. Mr. Hutchinson says of them: "What are called tertiary symptoms do not constitute a necessary stage of syphilis, and are to be regarded in the light of sequelæ." This statement is corroborated by the fact, now well determined, that the secretions of all such lesions are innocuous; and that neither they, nor the tissues, nor the blood of patients bearing such lesion contain a contagious element. Without the *contagium* there can be no syphilis. Ricord claims that tertiary lesions are not inoculable and cannot be transmitted by hereditary descent. Bumstead and Taylor (4th Edition) say, after reviewing this matter, "Hence we consider the blood and the secretions in tertiary syphilis innocuous." Diday performed inoculations with the blood of persons in the tertiary stage of syphilis, with a negative result.

If time permitted, I think it could be satisfactorily proven to you that the tertiary lesions of syphilis, are invariably due to obstructions of lymphatic spaces and channels, the result of simple pathological changes occurring during the active or contagious stage of syphilis. I will simply say that it has been determined, through microscopic examination, that *all* the lesions of tertiary syphilis are characterized by an accumulation of so-called gummy material, and that this gummy material has been found not to differ, in any essential respect, from normal germinal material, and that the damage associated with it, may, in every case, be fully accounted for, by the mechanical influence of its presence. It is to the occasional occurrence of tertiary lesions, in persons who have passed through the active stage of syphilis, that a persistence of the syphilitic diathesis, with all its power of communicating syphilis, for an indefinite

period, even possibly through the lifetime of a patient, is claimed. If, therefore, it can be absolutely proven, that the active or contagious stage of syphilis, does not last indefinitely, and that the lesions of the tertiary stage and the blood, during this period, are also free from the contagium, we may then hope to reach some definite limitation of the contagious stage of syphilis in all cases.

The acceptance of the degraded human germinal cell, as the true contagium of syphilis, and its logical sequences, as determined through our knowledge of minute physiology and pathology, will lead toward, if not definitely to, such a result. But it is to competent and well-authenticated clinical records, that we must now look for the solution of the important question at issue.

(To be continued.)

ON THE DIAGNOSIS OF SMALL-POX.¹

BY

PRINCE A. MORROW, A.M., M.D.

A PAPER upon so trite a subject as the "Diagnosis of Small-pox," may appear, in the estimation of many members of this Society, to demand an apology for its presentation. The diagnosis of a disease which is so characteristic in its mode of invasion, so regular in the order of its evolution, and so definite in the duration of the morbid process, would seem to offer few difficulties. But while the features of a typical case of small-pox are so striking and distinctive as to render it easy of recognition, yet the atypical, modified forms present so many points of similarity with other eruptive diseases that their early differential diagnosis may embarrass even the most practised physician.

Professional attention has been recently directed to the importance of this subject by the marked increase in the number of small-pox cases in this city within the past few months, and the apprehensions which have been excited of a threatened epidemic outbreak of the disease. The interest of the profession has also been awakened to the responsibility incurred in making a diagnosis of small-pox, by the fact that a reputable physician of this city has been mulcted in damages for an alleged mistake of this nature. It is not my purpose to comment upon the unjust and iniquitous character of the decision in this case. It involves a medico-legal question of great practical interest and moment to every member of the profession, and unfortunately, it will stand as a precedent unless it be reversed. The members of this Society have shown

¹ Read before the Medical Society of the County of New York, Jan. 25, 1886.

their recognition of this fact by an organized effort to have the case appealed.

Apart, however, from these accidental incentives to a quickened interest in this subject, the importance of the early diagnosis of small-pox cannot be over-estimated. In the case of most diseases, a correct diagnosis is chiefly valuable as furnishing indications for treatment, but in the case of a contagious disease it has a more important bearing upon the interests of others. We recognize a small-pox patient as a source of danger to all with whom he may come in contact; a centre of contagion to all who surround him. The recognition at the earliest possible moment of this source of danger and the prompt isolation of the patient, constitute the most efficient means at our command of limiting or circumscribing the spread of the disease.

As an example of the remarkable radiating power of the contagion, it may be stated that, in a former epidemic in this city, forty cases of small-pox in a public institution were directly traced to contact with a single attendant, the nature of whose disease was not recognized by the attending physician.

While it is important, in the interests of the public health, that the disease should be promptly recognized and the patient isolated, it is equally important, both in the interest of the patient and for the credit of the physician, that a mistake should not be made in the opposite direction and the patient sent to the hospital and exposed to the almost certainty of contagion from contact with small-pox patients. The laity are little tolerant of such mistakes and usually attribute them to ignorance, carelessness, or undue haste on the part of the physician.

Practically, however, we find that such mistakes are often made, even by the most careful and experienced physicians. The records of all small-pox hospitals are prolific in statistics of this nature. Marsden in his classic paper on small-pox (Reynolds' "System of Medicine," page 445) says, "Upwards of twenty diseases have been mistaken within the past few years, in the early stage of the illness, for small-pox and the patients have been sent, as having small-pox, to the London Small-pox Hospital."

Neumann, who had charge of the Vienna Small-pox Hospital in the epidemic of 1872-73, reports that thirty-five patients with measles, scarlatina, erythema, etc., were erroneously admitted as having small-pox.

The following statistics, taken from the records of the Small-pox Hospital of this City, from 1880-1885 inclusive, were kindly furnished me by Dr. F. W. Chapin. During this period, over 2,500 cases of small-pox were admitted into the hospital. Thirty-one cases wrongly diagnosed as small-pox are classified as follows: Typhus, 13; measles, 9; syphilis, 3; acute eczema, 1; varicella, 1; psoriasis, 1; acne, 1; purpura hemor-

rhagica, 1; malaria, 1;—making a total of 31 cases. On the other hand, eleven cases of small-pox wrongly diagnosed are thus classified: Typhus, 8; typhoid, 1; scarlet fever, 1; measles, 1. A total of 42 instances of mistakes as regards small-pox. In addition to these there was a much larger number of wrongly diagnosed cases which were received at the Reception Hospital in East 16th street and not transferred to the Island Hospital.

An examination of the record of the "Reports of Contagious Diseases submitted to the Board of Health of this City for the past twelve weeks ending January 16" discloses the fact that seventy-two cases of small-pox had come under the observation of the Health Board within this period. In addition to these cases of undoubted small-pox, thirty-eight cases were reported as such, which, upon investigation, were found not to be small-pox. An analysis of these 38 cases shows that the diseases mistaken for small-pox were represented as follows: Varicella, 17; syphilis, 5; measles, 3; lichen tropicus, 1; lichen, 4; vaccinia, 1; herpes, 1; pemphigus, 1; miliary fever, 1; sudamina, 1; erythema, 1; urticaria, 1. I have included in this list only such cases as were reported in the name of the attending physician, and have excluded therefrom quite a large number of cases which were reported through the telephone, by the police and other agencies. The large number of mistakes in diagnosis disclosed by this exhibit, it may be remarked, is the more significant considering the comparatively few cases of small-pox in the city. In the presence of an epidemic outbreak of the disease, when physicians are more keenly alive to the possible variolous nature of every doubtful eruptive disease, it may be reasonably inferred that a proportionately larger number of mistakes would occur. Incidentally it may be mentioned that at least two of the mistakes were made by physicians who presumably possess more than ordinary skill in the diagnosis of eruptive diseases, as both have been prominently identified with the teaching of skin diseases in medical colleges in this city.

These facts are not brought forward as an arraignment of the medical profession for carelessness or incompetency; they are not to be interpreted as an impeachment of the clinical judgment or diagnostic skill of the physicians making the reports. They simply illustrate the fact that in a certain proportion of cases of eruptive disease it is often impossible for the physician to pronounce positively upon the nature of the disease within the first twenty-four hours. However strongly the clinical signs may point in favor of the variolous character of the eruptive accidents, there are so many sources of error possible that the physician should suspend judgment until time clears up the diagnosis. Taken in connection with the recent interpretation of the law in the Purdy case, they emphasize the importance of the movement now on foot to

memorialize the Legislature to pass an act which shall secure to the physician exemption from all damages for compliance with the regulations of the Board of Health.

As before intimated, no other disease is characterized by more distinctive symptoms or is more readily recognized than a typical case of small-pox. The series of changes which the eruption undergoes in its development and decline are too familiar to be here described. They may be briefly referred to, however, in order to bring into relief the deviations from the ordinary evolution of the disease.

Small-pox ordinarily begins with a chill, succeeded by a fever with headache, severe lumbar pains, nausea, sometimes vomiting and other signs of constitutional disturbance. These symptoms subside with the appearance of a rash on the third day, in the shape of small distinct papules, hard and shotty to the feel, first appearing on the forehead, face, and back of wrists, successively invading the neck, trunk, arms, and lower extremities. On the fifth day, the papules are converted into vesicles which become depressed in the centre and surrounded by an areola. On the eighth or ninth day, the vesicles are transformed into pustules which, after the eleventh day, burst, discharge their contents and form scabs, which fall off, leaving pigmented cicatrices, the entire process being completed in from seventeen to twenty days. This series of symptoms and the regular order of their succession make up a clinical picture which is imitated by no other disease. While many of the symptoms are common to other eruptive fevers, yet the acute lumbar pain and the subsidence of the fever upon the appearance of the eruption are pathognomonic of small-pox. The same may be said of the eruptive features. The anatomical form of the lesions is not peculiar to small-pox, yet the poek occurs in other diseases rather as an accidental formation than a typical lesion; its mode and rate of development are altogether different.

The diagnosis of small-pox is usually difficult in proportion to the duration of the attack. In the early stage, when the premonitory symptoms are doubtful and the character of the eruptive accidents uncertain, the simple element of time resolves all doubt. A papular eruption, for example, which remains unchanged longer than two days, does not indicate small-pox, since the transitional stage of the small-pox papule does not surpass that period. However important the chronological element may be as a differential factor, practically we cannot always apply the test of time, since we are compelled to report an opinion within twenty-four hours after first seeing the patient, and this enforced precipitancy in making a diagnosis is the explanation of many mistakes which would not be possible at a later period, when the disease is more advanced in its evolution.

In the early eruptive stage, the premonitory symptoms, especially

when conjoined with a history of known exposure, are much more important from a diagnostic point of view than the eruption itself. The initial exanthem, especially when hemorrhagic, is, of course, pathognomonic, but it occurs with such a varying degree of frequency in different epidemics that its inconstancy deprives it of value as a diagnostic element.

It is, however, the modified forms of small-pox, and the cases characterized by the production of macular, measly, and hemorrhagic rashes, that occasion the most difficulties of diagnosis. Undoubtedly the chief element of confusion has been introduced by the practice of vaccination. Vaccination *denaturalizes* small-pox: it deranges the regular order of its evolution and effaces its most distinctive features. This modification varies in degree in different individuals, according to the efficiency of the vaccination and the proximity of its performance.

Varioloid may have nothing constant, nothing definite, either in its constitutional accidents, the character of the eruption, or the duration of the morbid process. The premonitories may be as severe and protracted as in true variola, or they may be slight and of but a single day's duration. The eruption, instead of beginning upon the face, may make its first appearance upon the chest, back, or extremities, it may be sparsely scattered or thickly disseminated. Some of the lesions may abort at the papular stage or the vesicle may represent the acme of development. There may thus be present at the same time abortive papules, dried up vesicles, and advanced pustules. Umbilicated vesicles which constitute the specific sign of small-pox may be entirely wanting. Desiccation may begin as early as the fifth day. It is very rare indeed that the eruption passes through the entire cycle of evolution typified by the true variolous process.

Notwithstanding the benign character of varioloid, it possesses the same contagious activity as true variola, and, from a prophylactic point of view, its early recognition and the prompt isolation of the patient is quite as important. A case of peripatetic varioloid may be a more efficient agent in spreading the contagion than a case of confluent small-pox.

Measles.—Passing now to the consideration of the differential diagnosis of the diseases most commonly mistaken for small-pox, it may be said that, in point of frequency, measles occupies the front rank. While the period of invasion is a little longer in measles, the initial eruption of some forms of small-pox is oftentimes indistinguishable from that of measles, especially when of the papular variety, and it does not appear so surprising that these diseases were so long regarded as identical.

In measles there is often a coincident development of the eruption upon the back and face, while in small-pox it first appears upon the face. The papules of measles are larger, softer, and of a more vivid hue, con-

trasting with the pale color and hard shotty character of the small-pox papules. The former give to the hand passed over the surface a smooth velvety feel, while the latter communicate a rough, harsh sensation. It is, of course, only at the onset of the eruption that such a confusion is possible; in the course of twenty-four to thirty-six hours the papules of measles become more macular, while the papules of small-pox manifest evidences of a vesicular transformation. Independent of the eruption, the most important differential signs are the absence of lumbar pain during the period of invasion of measles, the maximal development of temperature during the height of the eruption, and the coryza, lachrymation, and other mucous membrane symptoms peculiar to this disease.

Measles may also be confounded with a form of hemorrhagic small-pox, in which the measly eruption is succeeded by petechiæ which may constitute the only cutaneous expression of the disease, and the patient often dies of hemorrhagic small-pox without a trace of a vesicle being present or before any unequivocal signs of small-pox are manifest.

Varicella.—In the record of thirty-eight cases wrongly reported to the Board of Health as small-pox, there were seventeen cases of varicella. This relatively large proportion may be explained by the fact of the unusual prevalence of varicella in this city at the present time. A small contingent may have been reported by physicians who believe in the substantial identity of the two diseases—an opinion which was formerly generally held, and is still entertained by some authorities. Considering the close resemblance of varicella to modified variola in the mode of its development and the anatomical form of its lesions, it is not surprising that the two diseases should sometimes be confounded. This resemblance is rendered more striking in the exceptional cases in which varicella is attended with a high degree of constitutional disturbance, with distinctly umbilicated vesicles which are followed by sloughing of the skin and permanent cicatrices. Ordinarily, however, there is slight systemic disturbance or none at all. The rise of temperature follows, rather than precedes, the eruption which is often the first symptom that marks the disease. The eruption is most characteristically developed upon the back, but may be distributed over the entire body. The vesicles are superficial; they rise from a hyperæmic spot, rapidly mature, and attain their maximum development in one or two days; they are soft, globular in shape, rarely umbilicated, and unicellular in structure; their contents may be evacuated by a single puncture. The individual lesions pass through their successive changes in from five to ten days. An important differential feature is that the eruption comes out in successive crops, so that we may have the eruption in different stages of development at the same time. Another diagnostic feature is that varicella is essentially a disease of childhood; some authorities maintaining that the occurrence of a varicella-like

eruption in an adult would necessarily exclude the diagnosis of chicken-pox. Clinical experience would seem to prove, however, the susceptibility of adults, though in the slightest degree, to varicella.

Scarlatina.—The resemblance of the prodromic rash of small-pox to scarlatina is sometimes most striking. The absence of sore throat and the typical tongue of scarlatina, taken in conjunction with the symptoms of invasion, are important diagnostic points. The appearance of a papular eruption on the third day would resolve all doubt. In hemorrhagic small-pox the intense congestion and the dark-red color which sometimes precedes the hemorrhagic exanthem may simulate a scarlatinal eruption.

Typhus Fever.—In the statistics of the Small-Pox Hospital it will be remembered that thirteen cases of typhus fever were diagnosed as small-pox, and eight cases of small-pox were mistaken for typhus. It is, of course, only in one of the hemorrhagic forms of small-pox that such a mistake is liable to occur. The purpuric eruption of small-pox occurs at an early period and the patient rarely lives to the seventh day, at which time the eruption of typhus appears. In variola hemorrhagica, the purpuric spots are larger and are attended with hemorrhages from the mucous membranes and hemorrhages into the conjunctivæ. In typhus fever, there is active delirium and other mental disturbances, while in hemorrhagic small-pox the mind is perfectly clear. The exanthem of spotted fever (cerebro-spinal meningitis) may also be mistaken for the petechial eruption of small-pox.

Purpura Hemorrhagica, as well as the cutaneous hemorrhages of purpura simplex and peliosis rheumatica, have been mistaken for petechial small-pox. In purpura, the eruption first develops upon the lower extremities, and rarely extends to the trunk and upper extremities. The history of the invasion, the sudden advent of the eruption, and the absence of subjective symptoms are important differential points.

Syphilis.—The similitude of syphilis to variola, it may be inferred, was recognized by the older authorities in giving to the latter the name of "small"-pox, and the term variola-form syphilide, which is still employed by modern writers on venereal, would indicate the identity of certain forms of dermato-syphilis with the characteristic lesions of small-pox. There is not only identity of anatomical form, but also of development through the stages of papule, vesicle, and pustule. The similitude is heightened by the fact that in some rare cases syphilitic lesions may present well-marked umbilication. The differential points are the history of the case, the more sluggish development of the syphilitic lesions, the grouping of the eruption, the absence of subjective symptoms, and the probable presence of other evidences of syphilis. It is very rare indeed that a disease so polymorphic as syphilis does not present a number of dissimilar eruptive elements at the same time.

Lichen.—*Papular Eczema* may be mistaken for the commencing eruption of small-pox. Five cases of lichen are recorded in my list. Marsden states that “febrile lichen is more like small-pox, modified small-pox especially, than any other form of disease is, non-variolaous.” It must be observed, however, that the disease he alludes to as lichen febrilis or lichen agrius is classified in our nomenclature as a form of eczema. It is exceedingly rare that an outbreak of eczema is preceded with severe febrile symptoms. The systemic disturbance, if at all marked, is consecutive to the general diffusion of the eruption over extensive surfaces. Eczema is further differentiated by the more intensely red, itchy character of the eruption, the size and color of the papules, its irregular distribution, and especially by the non-implication of the mucous membranes.

Sudamina.—It would hardly seem probable that this eruption should be mistaken for small-pox, yet two cases, one of sudamina and one of miliary fever, were so reported. The dewdrop-like lesions of sudamina, their superficial character, and greater abundance upon covered parts would serve to differentiate the eruptions. Moreover, the vesicles of sudamina attain their complete development in a few hours, and remain unchanged throughout their course. Dr. Jacobi reports (*Med. Record*, 1882, p. 443) the case of a woman in Bellevue Hospital, in which he was unable to make a positive diagnosis during the first four days of the disease. The body was profusely covered with a sudamina-like eruption, the face being free, on fourth day her face became covered with an eruption, not characteristic, but sufficient to establish the diagnosis of variola. Dr. Janeway stated that similar doubtful cases are not rare.

Pemphigus and Herpes are recorded as having been mistaken for small-pox. In pemphigus, the larger size of the bullæ, their development upon an erythematous base, their hemispherical or globular form, and the rapidity of their evolution, would serve to distinguish them. The contents of the bullæ quickly become turbid or they readily burst, leaving excoriated surfaces; moreover, they come out in successive crops. Catarrhal herpes is a more or less constant attendant upon many febrile affections. The vesicles are always few in number, which, with their clustered character, their tendency to develop at the junction of the skin and mucous membranes, and the restriction of the eruption to these localities should serve at once to differentiate it.

Erythema and Urticaria.—It is only the papular forms of these diseases in which the eruptive element has any resemblance to that of small-pox. An attention to the invasive symptoms, the absence of fever, the localization, and other characters of the eruption, will serve to eliminate small-pox.

Acne has been mistaken for small-pox. In acne there is an entire absence of constitutional derangement, with no subjective symptoms.

The eruption is chronic in its course and limited to certain localities, papules and pustules are usually present at the same time, interspersed with comedones. The element of age is also a differential factor, as the development of acne is ordinarily limited to the period of early adolescence. The lesions are usually conical, and suppuration ordinarily occurs at the summit and not in the totality of the pustule. In the so-called acne varioliformis, or acne atrophica, the eruption is almost always confined to the forehead and margins of the hairy scalp. An artificial acne produced by the ingestion or external application of certain drugs has been mistaken for small-pox. Two cases of iodic acne recently came under my observation which had been diagnosed as small-pox and the patients sent to the small-pox hospital, but were thence transferred to the skin ward of Charity Hospital.

In concluding these hasty and imperfect observations upon this very important subject, I may refer briefly to the evidence of characteristic marks of vaccination as influencing diagnosis. In the case of a doubtful eruption, some physicians would be inclined to exclude variola if there were present marks of a perfect vaccination. But clinical experience proves very conclusively that vaccination, no matter how efficiently and recently performed, does not prevent small-pox. I have already referred to the marked modification impressed upon the disease by vaccination. In some cases, however, it does not materially mitigate the severity of the disease. Kaposi states ("Pathologie und Therapie der Hautkrankheiten," 1880) that vaccination affords no protection against hemorrhagic small-pox. "Purpura variolosa occurs as frequently in the vaccinated and unvaccinated and those who have passed through an attack of small-pox." In this connection it is well to remember that, exceptionally, a mild, modified form of small-pox may occur in persons who have never been vaccinated. The absence of all marks of vaccination, no matter how mild the symptoms, does not then necessarily exclude variola. On the other hand, an attack of small-pox does not protect against successful vaccination. Judging from a recent editorial in the *Medical Record*, there seems to be a lack of clear views upon this point. In the Purdy case, the argument upon which the prosecution seemed to place most reliance in proving the non-variolous character of the plaintiff's eruption, was the fact that she was successfully vaccinated three days after her admission to the hospital. It may be affirmed very positively that an attack of small-pox does not necessarily extinguish the susceptibility to vaccination. Jenner recognized this fact, for he states ("Facts and Observations Relating to the Variola Vaccinæ or Cow-Pox," London, 1880) that "although the susceptibility to the virus of the cow-pox is for the most part lost in those who have had the small-pox, yet in some constitutions it is only partially destroyed, and in others it does not appear to be in the least

diminished." The statistics upon this point, cited by Mr. Seaton (Reynolds' System of Medicine) show that of 1,000 soldiers in the British army who had marks of previous small-pox, vaccination gave a perfect result in 450; of 1,000 men who bore good marks of previous vaccination, the result was perfect in 484; of 1,000 who bore no marks of previous vaccination or small-pox, only 326 were successfully vaccinated. In the *Medical Record* for 1881 are reported a very large number of cases in which vaccination was perfectly successful in those who had had small-pox. To allude to only one report (p. 475), 106 men in a factory were vaccinated, 7 of whom had had small-pox, the result was perfect in 6; of 2 who had had varioloid, 1 was successfully vaccinated.

The limited experience upon this point no doubt arises from the fact that vaccination is rarely performed after the patient has passed through an attack of small-pox, since the operation cannot be urged either in the interests of science or for the practical advantage of the patient.

Whether susceptibility to vaccination exists immediately after an attack of small-pox, or whether it is temporarily extinguished and regained only after the lapse of a certain time, are points which have not been definitely determined.

66 WEST 40TH STREET.

A CASE OF IODIC PURPURA.

BY

ETIENNE C. VIDAL, M.D.,

Attending Surgeon to New York Dispensary for Skin Diseases.

C. R., 50 years old, consulted me for a debilitated condition of the system, so pronounced in character that it was with the greatest difficulty that he could make the least exertion, this latter always being followed by complete exhaustion. The patient had been under treatment before consulting me, but had obtained no relief. I found him affected with a serious case of cardiac hypertrophy. But this did not account for the debility from which he chiefly suffered. Suspecting that it depended upon some remote cause, I submitted him to close questioning, and obtained an avowal that some twenty years before he had had syphilis, for which he had undergone only a few months' treatment. I ordered him pot. iod. gr. xv., three times daily. Under this, after a week's duration, there was an evident amelioration of the symptoms. The remedy was continued. About three weeks later I was called to see the patient for a dropsical effusion affecting the lower extremities as high as the knee, and the feet. I should state, in passing, that he had had a pityriasis versicolor, involving the neck, chest, back, and arms. It had

existed during the same period mentioned above, and was as evident when I saw him, the patient stated, as it had ever been, but as it never disturbed him he had done nothing for it. Upon examining the inferior members, I discovered a bright red, macular eruption, ranging from the size of a pin-head to that of a split pea, persisting under finger pressure. The dorsal surface of the feet was especially affected. The patient complained at the same time of severe pain in the thighs and top of the feet. The body at the same time offered a number of papules of an acne character. I discontinued the pot. iod., and the purpuric eruption gradually faded away. Believing that it was a case of iodic purpura, I again ordered the medicine in the same dose, his general condition having improved under it, and a week later was a second time confronted with a similar eruption. After discontinuing the iodide to resume it the second time, the purpura appeared for the third time. I now lost sight of my patient, but I am of the opinion that under the same treatment the eruption would have been repeated indefinitely. The patient's health at no time offered any other evidence of the toxic effect of the drug, but, on the contrary, improved so that the man could attend to his business, and ascend long flights of stairs without feeling other inconvenience than increased heart pulsation.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

160TH REGULAR MEETING, JANUARY 26, 1886.

DR. W. T. ALEXANDER, *President*.

DR. JACKSON presented a case of

ROSACEA HYPERTROPHICA.

Mr. B., U. S., æt. 51; Janitor. Twenty years ago the patient had an eruption which was pronounced eczema. Denies all venereal diseases. Has been a hard drinker. Suffers frequently with headaches. Has dyspepsia. His tongue is coated white. His bowels are regular.

The patient was first seen September 1, 1885. He came to the hospital on account of his nose which was red, nodular, and very much enlarged. He stated that he had had this trouble with his nose for six months. The left side of the nose was a little larger than the right. There were six or eight superficial, generally oval ulcers upon his nose, especially on the right side. These were partly covered by a thick yellowish-brown crust. On the left side of the nose, on the lower part of ala, was a patulous, small opening which led down into a deep, though narrow pocket. Into this a probe was passed to the depth of one-half inch. There was no disease of the inside of the nose. There were two small, irregular

scaly patches upon the palmar surface of the third finger of the right hand. He was treated by multiple scarifications, with local hot-water bathing at night, followed by white precipitate ointment; and internally by tincture of nux vomica. He was irregular in attendance, but nevertheless steadily improved. On November 3, he was given "mixed treatment," which he took for one week. He did not present himself again till December 29, when he was much better, the nose being smaller, and the redness reduced all but on the tip. Many dilated blood-vessels were found on the nose and cicatrices from the ulcers. He said that up to ten days before this, his nose looked finely, but then began to grow worse.

In presenting the case, Dr. Jackson asked the opinion of the members as to whether it were a simple breaking down of the tissues or if syphilis were superadded.

DR. TAYLOR had seen a similar breaking down of the tissues in those affected with albuminuria, hard drinkers, or those who had cardiac disease. He believed the present lesion to be due to a disintegration or necrosis of the tissues. Vascular changes take place in albuminuria, and in this case we have changes due to inflammation superadded.

DR. BRONSON thought that in this patient, the depressed cicatrices occurring in groups, especially on the right side of the nose, suggested the existence of syphilis in addition to the inflammatory process. He did not know how the condition could be produced otherwise.

DR. STURGIS believed the case to be one of rosacea and that syphilis was not present.

DR. SHERWELL said that when the tissues were once degraded, they would go on to necrosis. He had seen cases where syphilis was added to rosacea.

DR. FOX showed a case of

PAPILLOMA OF THE FOREARM.

Four or five years ago, the child's mother noticed a dark mark which appeared over the ball of the left thumb, and which gradually spread. Now there is a warty condition of the ball of the thumb; the lesion extending on the flexor surface of the forearm, forming an irregular patch about an inch and a half or two inches broad. A short time ago, a dark line made its appearance on the inner side of the arm. The lesion is of a dusky red and considerably elevated above the surrounding healthy tissue; it apparently follows the course of the nerve.

DR. STURGIS said that the lesion looked very much like a neurosis.

DR. MORROW had seen cases like this with a similar distribution, and in all of them there was a history of some antecedent injury. He would suspect that there had been some injury to the nerve supplying the parts, the seat of the eruption, which had escaped the child's and mother's notice.

DR. MORROW then exhibited a case of

KERATOSIS FOLLICULARIS,

an account of which will be published in a subsequent number.

DR. TAYLOR thought that it was rather premature to give a name to the lesion until the contents of the projecting spines had been examined microscopically.

DR. PIFFARD would take exception to the name given. He considered the lesion to be a sebaceous disease or an affection of the corneal layer.

DR. ALLEN thought that the matter expressed from the diseased portions of the skin was a mixture of epithelium and sebum.

DR. BRONSON believed that keratosis pilaris was a proper name. He considered it to be a disease of the sebaceous follicles with prolonged comedones, and that it was the same disease with which the "bristly" boy was affected. The question if syphilis were present was an interesting one, and also whether the same causes

which produced the diseased condition of the tongue also produced the lesion on the body.

DR. FOX considered the case to be one of keratosis pilaris. The "hedge hog" man and "bristly boy" were examples of congenital disease.

DR. STURGIS believed the lesion on the body to be a keratosis and that on the tongue syphilis. The kerato-iritis was decidedly syphilis.

DR. BULKLEY thought the lesion was a degenerative disease of the sebaceous glands, and that keratosis pilaris was an appropriate name. The horny matter is produced by a hardening of the sebaceous glands.

DR. ROBINSON said that it was useless to discuss the question of a name for the disease, when the pathological conditions present were not known.

DR. MORROW had not examined the spinous projections microscopically, but he had otherwise examined them carefully. They seemed to be drier and harder than comedones, as if the transformation into oily matter had not been completed. He did not see what possible influence syphilis could have on the production of the disease because the chancre dates back only a year, and the lesions on the skin and tongue have been present at least five years. The patient is a sailor and has had to abandon his occupation because he gets worse when at sea and improves when on land.

DR. FOX then showed a case of

GENERAL ALOPECIA FOLLOWING KERATOSIS.

The patient, a man about 35 years old, has a general alopecia of the head and body following keratosis pilaris. The hair all over the body and scalp has fallen out, commencing on the scalp, where it fell out in patches. The patient has had syphilis, and the question arose whether the alopecia was at all due to the presence of that disease.

DR. BULKLEY presented a case of

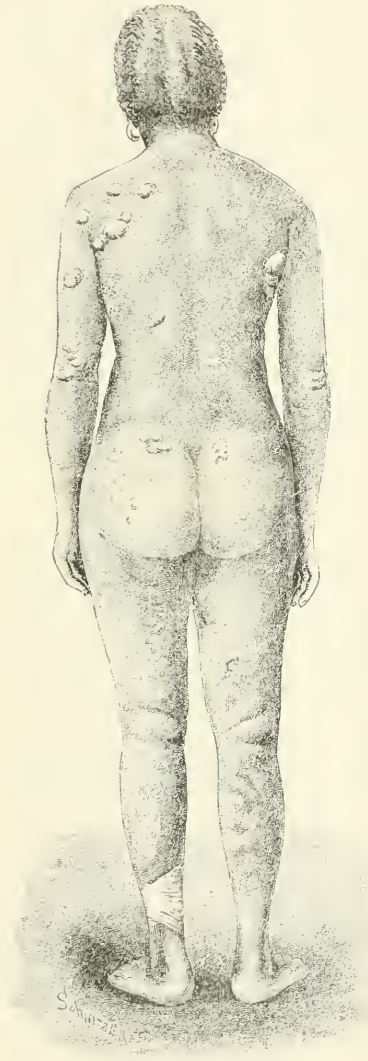
DERMATITIS HERPETIFORMIS.

DR. SHERWELL afterward presented a case of

NON-VENEREAL SYPHILIS.

Miss J. W., æt 20. Was first seen Dec. 24. At that time she had a sore on the lower lip, with an indurated base, which had been present about one

month. The glands at the angle of the jaw were much enlarged and indurated. A fading primary erythematous eruption was also found. The case was shown on account of the relative infrequency of primary sores occurring in this region,



with such a clear subjective and objective history. The exposure to the contagion occurred about the last week in October, 1885.

DR. PIFFARD presented photographs of

A CASE OF KELOID HAVING SEVERAL POINTS OF INTEREST.

The patient was a female mulatto, aged 35 years, and a native of South Carolina.

The disease had first made its appearance about ten years ago, as various-sized elevations of the skin in the region of the neck and shoulders.

Later on, the lesions became generalized over the whole body, and around the neck took on a peculiar form, encircling the throat in a double coil. The patient had been insane a number of times and had thought this lesion about the throat to be a snake.

The interest of the case rests in the fact that, while new lesions have kept appearing from time to time, many of the old ones have spontaneously disappeared, by a process of involution or retrogressive metamorphosis. The site of each lesion which has thus disappeared is marked by a pigmented spot or stain.

Dr. Piffard called attention to the tendency to fibrous hyperplasia in the mulatto race, as evidenced by the great frequency with which keloid is met with among them and the great tendency they show to uterine fibroids.

DR. PIFFARD also described an apparatus by means of which

PHOTOGRAPHY WAS MADE EASY.

It consisted of a camera with a sufficient number of plates to take twenty-four photographs. The negatives were taken on paper instead of glass, and a paper prepared in bromide of silver was used for printing the photographs. The bromide of silver produced a clearer and better photograph.

DR. TAYLOR then read a paper on

"HYDROA BULLEUX AND KINDRED AFFECTIONS,"

which will appear in the April number.

Selections.

SOME MOOT POINTS IN THE NATURAL HISTORY OF SYPHILIS.

Mutual Relations of the Different Forms of Primary Venereal Sores.

I HAVE long thought that, if the question in debate could be once clearly stated, the duality or unicity of venereal poisons would soon cease to be a moot point. We are pretty much agreed as to the facts, and the controversy is mainly as to what they imply. A dualist is, I suppose, one who holds that there exist two quite distinct and independent contagia, one of which produces a non-infecting sore, and the other syphilis. An unicist holds, somewhat differently, that the poison of the soft sore is a product of syphilis, and by no means independent. The difference after all is not great, nor clinically is it of much importance. No one thinks that there are two forms of syphilis, and no one doubts that there are two kinds of sores. Are they related and independent? that is all that we dispute about.

The fact which chiefly favors the creed of those who think that that they are independent is, that the secretion of the chancroid is very contagious, and always produces a sore like itself.

Danielsen tried the practice of inoculating chancroid on a number of lepers who had never had syphilis. He found that he could reproduce a soft sore over and over again, and that it was never followed by syphilis. In further proof that no syphilis was conveyed, it may be stated that one patient, who had undergone many inoculations without ill result, finally by accident received virus from a true chancre, and had, as a consequence, an attack of true syphilis.

All inflammatory products are probably, under favorable conditions, contagious. The gonorrhœal secretion produces gonorrhœa, that of erysipelas, erysipelas, that of diphtheria, diphtheria, and so on. It is probable, however, that each of the diseases may originate spontaneously, and quite independently of contagion. The contagia are, therefore, the products of inflammation. Further, it is highly probable that, in each of the diseases mentioned, the contagium may vary much in virulence, and that it is by no means always the same. Probably it is quite possible to breed them up to higher degrees of power and of special peculiarities. It is possible then that the poison which produces the chancroid is, after all, only a specialized product of inflammation, and not a specific virus.

Many facts seem to support the conclusion just hinted at, and to imply that soft sores are, after all, an appanage of syphilis. When care is taken in inoculation, unquestionably they seem to breed true; but this is not the case in those which we see in practice as the results of accidental contagion. If we place in one group as "soft" all the venereal sores which do not harden, and which do not infect the system, we shall find that but a very small proportion of them present what are considered typical characters of the chancroid. We encounter a great variety of conditions and great differences in course, and are obliged to conclude that they agree in one feature only—the absence of hardness. The rounded form, punched out and ragged edges and gray base, are conditions not present in my experience in one of five of the venereal sores which do not harden.

It would be waste of time to attempt to describe the multiform character of non-indurated sores. Many of them are small, almost level with the surface, and have shelving edges. How rarely do we witness the inflammatory bubo tending to abscess which is said to accompany them. How short, as a rule, is their duration. Whilst the typical chancroid goes through stages, and usually lasts six weeks, a few dressings with iodoform suffice to cure in a week almost all the "soft sores" that we meet with in practice. Now and then, I admit, we encounter the true chancroid as graphically depicted by Mr. Lee, but it is very exceptional. This want of uniformity in conditions is a strong argument against specificity. Another equally strong argument is that the true chancroid on the genitals is seldom seen, except in those who have had syphilis already. If a person who has never suffered before contracts a venereal sore of any kind, it is highly probable that it will lead to syphilis. In using this argument, I by no means wish to deny that the typical chancroid is sometimes seen in those who have never had syphilis.

Very important evidence as to origin of the chancroid, and of all non-indurated venereal sores, from syphilitic secretions, is afforded by at least two experimenters. Mr. Morgan, of Dublin, inoculated with purulent vaginal fluid from those who have had syphilis, and found that he could with it produce the typical chancroid. From the sores thus produced, he could inoculate repeatedly and with

sameness of results. With praiseworthy caution, he never inoculated excepting in those who had previously had syphilis; and thus, whilst his facts are conclusive as to the production of soft sores, they do not prove that syphilis might not very possibly have been produced at the same time had the soil been suitable. Mr. Lee had previously recorded the possibility of producing from indurated sores, by artificial irritation, a secretion which is purulent, and which is inoculable on the patient, producing a sore not distinguishable from chancroid. Mr. Gascoven, Bidentkap, and others had, I believe, done the same. It is surely very difficult to get over these facts; whilst, to push the argument further, so far as I can see, all *a priori* probability favors the suggestion that non-indurated sores are produced by the secretion of true chancres, which have been changed in character either by the inflammatory process, or by the non-susceptibility of the tissues of the recipient.

Phagedæna.

A parallel of much importance might, perhaps, be drawn between the chancroid processes and phagedæna. All will admit that syphilitic inflammations have a remarkable tendency to become phagedænic. This may occur in all stages of syphilis, and to all kinds of sores. Is it not necessary that there should be any contagion of material from phagedænic sores; it is sufficient that there is syphilis, for syphilis in its purest form often leads to phagedæna. Phagedæna, as we see it in connection with syphilis, is almost invariably of spontaneous origin, or, in other words, caused by syphilitic inflammation, and not by phagedænic contagion. There is every reason to believe that its products are contagious, and that they would probably produce phagedæna, and not syphilis. The specific virus of the latter is probably destroyed in the gangrenous process. When phagedæna spreads as such by contagion, we encounter it, as I shall have to assert directly, under other aspects, and not as a venereal disease. Now, the chancroid type of inflammation is possibly only a sort of minimized phagedæna, and differs from it only in degree. Its virus is probably produced under similar conditions, and it is curable under the same methods of treatment. The fact that a chancroid in a woman does not absolutely disqualify for sexual congress, makes it possible for it to be transferred as such by direct contagion. This fact it was which misled Bassereau and his followers into the belief that the virus of these sores possessed specific individuality. Probably it is not so; and it is still likely that many chancroids originate spontaneously in the same sense that phagedæna does; that is, they result not from contagion of a sore of the same kind, but from a modification of a syphilitic inflammation by peculiarities of the individual. Be this as it may, it is to be freely admitted that chancroids are very contagious, and that they reproduce themselves with closely similar features. Their virus, if not specific, is at any rate well specialized.

Hospital-Phagedæna.

Closely connected with this topic, and of great clinical interest, we have the question of the origin of hospital-phagedæna from syphilis. It is not uncommon to see the disappearance of hospital-gangrene claimed as one of the triumphs of antiseptic practice. I hold this to be a mistake. The truth respecting hospital-phagedæna is, that it did not exist in one of ten of our hospitals at the time when antiseptics came into vogue. It is not a disease which is always with us, but rather one which comes occasionally, prevails extensively, and then disappears. It is not due to neglect of cleanliness, nor to atmospheric infection; it does not occur from overcrowding; but it is caused by a special form of conta-

gious pus. The suggestion that hospital-phagedæna take its origin from syphilitic phagedæna, would fit well with the fact that it often prevails in military hospitals, especially when crowded, in time of war.

Accepting the hypothesis of its syphilitic origin, we have then a parallel fact to what is observed in the case of the chancroid. A specialized contagium (pus) has been bred up, which can produce its like wherever inoculated, but which does not contain the virus of syphilis. Both the chancroid and the phagedæna are the products of a poison originating in syphilitic inflammation, but which in neither case can induce syphilis. It is easy enough to see that, if once the particulate virus of syphilis have died out of a secretion, the latter may then be propagated over and over again without the slightest possibility of reproducing the defunct specific elements. It is not, therefore, to be wondered at, that neither the chancroid nor hospital-phagedæna, although appanages of syphilis, ever, when once negatively specialized, by any chance produces that disease.

It is a question about which there is still some debate, whether the infecting or the non-infecting sore is the more liable to phagedæna. My own experience would lead me to a very definite opinion, that almost all sores which are attacked by this process are true chancres, and that it occurs at a stage too late to prevent absorption. It is, in fact, a concomitant of a true syphilitic inflammation, and does not usually happen until induration has taken place. It denotes unusual susceptibility to the influence of the virus, and it is often followed by very severe secondary symptoms. I will by no means deny that the retention of irritating secretions, as in phimosis with concealed sores, may give rise to gangrene of the foreskin in cases where no syphilis exists. If, however, a typical phagedænic process be set up, and spread, I believe that it will almost invariably be in association with true syphilis. I have suggested that the chancroid process is allied to that of phagedæna; but it appears to be well specialized, and quite capable, under most circumstances, of maintaining its individuality. When once its peculiarities have been declared, the sore seldom deviates much from its type. If it do become aggravated, and spread at its edges, such spreading is only of the very mildest form of what we mean by phagedæna.

A knowledge of the fact that phagedæna usually goes with true syphilis is of much importance for purposes of retrospective diagnosis to those engaged in medical practice. Not unfrequently, with symptoms of visceral or nerve disease, an examination of the genitals is made in order to seek for scars. Whilst some have assumed that scars on the penis, or its extensive malformation by bygone phagedæna, imply the probability of syphilis, others have asserted that they rather favor the belief that the disease was not true syphilis. My vote would go with those who regard them as important, though not conclusive, evidence of constitutional disease. I have very seldom seen scars on the penis in patients who had not had syphilis, and still more seldom the evidences of phagedænic action.

I am compelled also, as the result of personal observation, to deviate yet further from the popular creed, and to say that I should regard scars in the groin as also presumptive evidence of syphilis. Our rules of diagnosis have been, I cannot but think, far too definitely laid down on these matters. In private practice it is very rarely indeed that we have to deal with inflamed bubos. It so happens that, of late years, almost all the cases of suppurated bubo which I have seen were cases of syphilis. It is not, I believe, on the other hand, very exceptional for the typical chancroid to cause no enlargement of the glands at all. That an uninflamed

indurated sore will be attended by uninflamed indurated glands I fully admit; but the fact remains, that a great many infecting sores do inflame and suppurate, and when that is the case the glands will follow suit. Nor is this inflammation always the result of a mixed contagion: it often, I feel sure, results from personal proclivity in connection with a fairly pure syphilitic virus.

A series of cases of syphilis from circumcision, which I have recently, in association with my friend, Mr. Charles Macnamara, had an opportunity of investigating, is of much interest in reference to the question just discussed. We were shown a group of six infants, all of whom had constitutional syphilis, having been infected by the same operator in the rite of circumcision. In all the operations, the wound had reopened, and assumed the conditions of a chancre. Two out of the six had double suppurated buboes in the groin, and two others had large masses of agglutinated glands. The children had all been healthy before the operation; and I cannot but think that their age had probably much to do with the unusual tendency to suppurative inflammation displayed.

The recognition of non-infecting venereal sores on other parts than the genitals, whether on the hands or elsewhere, is a matter of great difficulty. I have myself very seldom indeed seen sores on the fingers of surgeons which could be reasonably supposed to be due to vaginal infection, which did not prove to be true chancres. I do not recollect a single instance in which a sore on the hand, which was not a true chancre, produced a bubo in the armpit. Although I have treated possibly a hundred cases of chancre on the finger, I never yet was concerned with a suppurated bubo in the armpit in association with a venereal sore on the hand. This is a very remarkable fact, and may be held to indicate either that the so-called "soft sore" is rare on the fingers, or that it but rarely causes bubo. Probably both explanations are in turn true.

Second Attacks.

In 1839, Ricord made the important observation that a person who had once had syphilis was not liable to have it again. Although he believed that exceptions to this law were possible, and was anxious to admit them, yet, up to 1858, he had met with none which satisfied his mind. In the following year occurred the first case in which he himself witnessed and treated two attacks of undoubted constitutional syphilis in the same patient. The interval was nineteen years. Diday recorded many exceptional cases, and thought that the second attack occurred when the first was incomplete, and in some sense supplemented it. Thus, if the patient's skin had suffered in the first, and his mucous membranes escaped, the reverse would be the case in the second. Later on, Gascoven and Fournier published many exceptional cases. I have myself seen many in which the patient's narrative was clear that he had had a former attack, and several in which I myself attended the patient in both. It is, I think, now generally accepted that second attacks after considerable intervals are not very uncommon; but, at the same time, that Ricord's law holds good in reference to a very large majority. The exceptions—that is, second attacks—are probably not more frequent than in the case of variola and measles.

As a rule, when a patient contracts syphilis a second time, it is after an interval of many years, and after, apparently, very perfect recovery. Neither of these statements is, however, absolutely true; I have seen a well characterized indurated chancre due to fresh contagion, within a year of the first, and before the patient was well rid of his symptoms. I have repeatedly seen them in those who still suffered from reminders of their former attack.

I have had in my own practice the following case: A gentleman contracted a chancre in February, and took mercury until the hardness disappeared, but no longer. In May, he had rash and sore throat, and again took a short course of mercury. Having left it off for a month or more, he returned, in July, with another chancre, which he believed to be the result of a fresh contagion which was not in the site of the former one, and which presented the most characteristic induration. This sore yielded but slowly to mercury, and was followed by rupia, and eventually by periostitis.

Incubation Periods.

It may seem strange that, after the amount of attention which the natural history of syphilis has received from many excellent observers, the length of the incubation-period of chancre should still remain a moot point. The differences of opinion are, however, very great. Thus, Ricord said that induration occurs most frequently during the first or second week after contagion; never before the third day, nor after the third week. Sigmund, of Vienna, dealing with 261 observations, found only three with an interval as long as three weeks, and none with longer: whilst in as many as seventy-one it was only nine days. Other observers have given longer periods. Mr. Berkeley Hill, making use only of experimental inoculations, has constructed for us a table which seems to prove that the average period is twenty-four days, the extremes being ten and forty-six. This table comprises thirty-seven cases. Fournier and Clerc give it as twenty-one days. It is admitted that neither differences in the source of contagion nor in the part affected make any difference in the length of the period during which the poison remains quiet. If I were to speak from my own experience only, I should be inclined to make the incubation period longer than any of the observations just quoted, and am obliged to admit that the statements of Sigmund and Ricord are almost inexplicable. I can only suppose that there has been some misunderstanding as to what phenomena constitute the limits of that period, or that it has even been counted, not from the date of the contagion, but from the first appearance of a sore. In this last supposition I am countenanced by Dr. Taylor, of New York, the very able editor of the last edition of Bumstead's work. If by incubation-period we mean, as I contend we ought to do, the interval between contagion and the production of an induration which can be diagnosed, then I believe we shall seldom find it less than five weeks, and more often six. If we date to the first appearance of a sore, then it will be a week or ten days shorter, for the development of hardness takes that time. In these statements we, of course, put aside the very numerous cases in which a sore is present almost from the first, the chancre having been a mixed one.

Recurrent Chancres of False Indurations.

In connection with the doctrine as to second infection, it is very needful to appreciate the fact that chancres may recur. Briefly, it is quite possible, and not a very rare occurrence, for indurations to develop in the retrocoronal fold of the prepuce, which assume the most exact resemblance to hard chancres, but which are not consequent on any fresh contagion. They occur to those who have had syphilis, and usually, but not invariably, on the site of former chancres. They may happen repeatedly to the same individual, and cases in which this occurs afford the clearest proof that they are not newly contracted sores. They may occur at very various periods after syphilis, but usually within five years. Thus they are not to be associated with

the phenomena which are definitely tertiary; at any rate, not so in many instances. Nor do they, as a rule, resemble tertiary gummata in the tendency which the latter have to grow irregularly and to a large size; nor do they usually break down or slough like gummata. For the most, they retain throughout the most exact resemblance to the ordinary collared chancre, and they are often wholly without ulceration. For myself, I have never, with one exception, seen them in any other position than that mentioned, the fold of mucous membrane just behind the corona, the most ordinary position for the best characterized primary sores. No doubt the development has something to do with the anatomical peculiarities of this part. Under mercurial treatment they melt away very quickly, and they are, I think, rarely attended by enlargement of glands, and never followed by constitutional disease.

The case in which a chancre, not on the penis, recurred was one in which disease had been due to vaccination. In this instance, about four years after the first disease, one of the scars, which had for long been perfectly sound, again inflamed and became dusky and slightly hard at its edges. Mercury very quickly, as a rule, but not always, takes away these recurrent chancres, and they are not, I believe, usually attended by any other proofs of tendency to recrudescence of the constitutional taint. I have known at least one instance in which a gentleman had his chancre indurate again repeatedly during several years, and generally with about a year's interval between the attacks, and yet he remained otherwise in perfect health. I am not sure that, in some cases, the induration may not subside spontaneously, but I have never tried the experiment of leaving them without treatment.

On Induration as a Symptom and on Syphilis without Chancre.

That we have been in the habit of attaching far too much importance to the condition of induration as an almost essential characteristic of the initial lesion of syphilis, the observers of to-day are, I think, pretty well agreed. When a sore takes on induration, it is, provided, first, that the patient has never had syphilis before, and, secondly, that no caustic has been used, a certain indication of coming syphilis. But the absence of induration goes for very little in the way of evidence, and it may vary in degree and in duration within very wide limits indeed. In many cases, it lasts only a very short time, and is only very doubtfully marked; in others, it may, in size and duration, simulate a new growth.

If, however, we admit all this, we may still hesitate to admit that syphilis can begin without any chancre whatever. Yet for practical purposes that is the conclusion to which we must come. In other words, there are cases in which the closest scrutiny, aided by a patient who is not only candid but skilled as an observer, wholly fails to discover any initial lesion. These cases divide themselves into two groups, those in which an attack of gonorrhoea preceded the constitutional symptoms of syphilis, and those in which no local disease of any kind was observed. Both of these groups are, I believe, fully recognized by most authorities. Respecting the last, it is undoubtedly possible, indeed, in most instances, probably true, that a chancre had been present and had escaped recognition. Thus in the mouth, and especially on the tonsil, a sore, which was really the primary one, may not have been noticed until other symptoms appeared, and may then have been counted as part of the secondary group. I have seen several instances of this. On the genitals in women very frequently, and in men sometimes, a small indurated sore may cause such slight irritation that its existence is never discovered. But, making every possible allowance for such sources of fallacy, there

still remain a few cases in which careful observation from the beginning has quite failed to find a sore, and in which every possible region has been searched. Is it possible that intra-urethral chancres may occur without pain, without signs of obstruction, without external hardening, and without discharge? Such is the suggestion of some, but it does not seem very probable.

Gonorrhœa-Syphilis.

The frequent occurrence of cases in which syphilis follows what was considered to be only gonorrhœa, suggests the suitability of recognizing what we might call gonorrhœa-syphilis. It is known to all that Hunter regarded the poison of gonorrhœa as identical with that of syphilis, and, no doubt, it was the occurrence of cases such as I now refer to which had caused his belief. There is no danger now that the name I have proposed should mislead any into adopting again his erroneous generalization. Cases of gonorrhœa-syphilis must be familiar to all who have opportunities for observation. The urethral inflammation is exactly like that of gonorrhœa, and by no means suggests a urethral chancre; and, in many cases, the urethra has been examined carefully with the hope of discovering local induration or a tender spot without result.

Mr. Hill has recorded an interesting case, in which the only initial lesion discovered was a general hardening of the whole penile urethra (presumably with gonorrhœal discharge). In explanation of these facts, it may be admitted at once that there is nothing in the least improbable in the supposition that the particulate virus of syphilis may exist in gonorrhœal pus. If a patient, the subject of secondary syphilis, should contract gonorrhœa, no doubt the virus would pass into the discharge, since we know that it is present in the blood, and finds its way into all products of inflammation. Witness its presence in the transparent lymph of the vaccine vesicle. Given, therefore, a person suffering from both gonorrhœa and syphilis, what would be the probable result of contagion? Very likely, as is often seen, a gonorrhœa immediately and a chancre four or five weeks later; but if the latter were omitted, it is still conceivable that the gonorrhœa might allow the absorption of the virus. Possibly, the acute inflammation of the urethra may act in preventing the local adhesive inflammation, which constitutes the conspicuous part of a chancre. This seems a more probable hypothesis than that the virus is absorbed directly, without the intervention of any sore at all. It is to be noted that in gonorrhœa-syphilis there occurs usually definite induration of the inguinal glands.

Syphilis conveyed in Vaccination with Clear Lymph.

A question which was a few years ago in dispute, but which has, I may say unfortunately, been finally set at rest, is the possibility of conveying syphilis by translucent vaccine-lymph. The belief that it was necessary to draw blood, or, at any rate, to allow the vesicle to drain after emptying it, and thus permit the escape of fresh leucocytes, can no longer be entertained. One of our own profession, with that enthusiasm for knowledge which Hunter displayed in a parallel experiment, made himself the victim, and placed the facts beyond the reach of doubt. The facts of the case are probably known to many present; but as they may be new to some, I may be permitted to relate them. They came under my personal cognizance, but, for obvious reasons, I do not mention names. The gentleman to whom I refer vaccinated his own arm repeatedly, and in many places, from syphilitic infants, being very careful on every occasion to use only clear lymph. On the first two occasions he

failed, but on the third he succeeded, and three indurated chancres were the result, followed in due course by constitutional symptoms. The incubation-periods I have already mentioned, the punctures inflamed on the twenty-third day, and were well indurated on the forty-first. It is impossible not to admire the self-devotion which prompted to this experiment, and especially to the perseverance and repetition of it. Had that repetition not taken place, and had a report of results been given to the world after the first two trials, how strong would have been the conviction of all in the truth of the creed that pure lymph, even from infected vaccinifers, is safe. Not often, probably, has our science had so near an escape of being encumbered by a false fact.

The interest of this demonstration does not end with its relations to the practice of vaccination. It proves that the virus of syphilis may exist in a perfectly clear fluid, and in company with that of another specific fever. We know from experiments that if the purulent secretion of soft sores be filtered so as to get rid of pus-cells, it is no longer inoculable. The converse is probably true of the virus of syphilis. The contagium of the one is pus, that of the other the particulate micro-parasites of a specific fever.—JONATHAN HUTCHINSON, *Brit. Med. Journal*, Jan. 9. 1886.

NERVOUS TROUBLES IN SLOW MERCURIAL INTOXICATION.

1. SLOW mercurial poisoning gives rise to a certain number of nervous troubles which constitute the greater part of its symptomatology.

2. These nervous troubles can be attributed, in part, to the presence of mercury in the nervous centres, where it has frequently been found, and in part to lesions of the cerebro-spinal system, which have been described by Wising. One of the most curious characteristics of these lesions is the persistence of the axis cylinder in the altered regions. This last condition is found in the lesions of sclerosis in plaques, which, moreover, in its clinical features shows some analogies with cerebro-spinal hydrargyrosis.

3. The nervous troubles of hydrargyrosis are :

a. Disturbances of motion : trembling analogous to that of sclerosis in plaques; convulsive phenomena of various kinds (cramps, epileptiform attacks, etc.), choreic movements, apoplectiform ictus, paralyses presenting the features of paralysis of cerebral origin.

b. Disturbance of sensibility: anæsthesia presenting the features of anæsthesia of cerebral origin: painful phenomena of which the most constant are the arthralgias and cephalalgias.

c. Disturbances of a psychical nature which are at first excessively emotional: disturbances of sleep, vertigo, and, toward the last, dementia very much resembling senile dementia.

4. In general, these nervous disorders persist for a very long time; they may be greatly benefited, but only rarely can an absolute cure be obtained.—PHILIPPE MARÉCHAL, *Thèse de Paris*, 1885.

STUDY OF GENITAL HERPES IN MAN AND IN WOMAN.

1. GENITAL herpes is almost as frequent in women as in men.

2. In women, the eruption is more abundant; in men, confluent eruptions are excessively rare.

3. In man, recurrent herpes is quite common, while in the woman it is symptomatic herpes that we observe in the larger number of cases.—NUMA PINTO, *Th. de Paris*, 1885.

THE PREVENTION OF GONORRHŒA.

ALTHOUGH it has generally been the view of physicians that, aside from the regulation of prostitution, it has not been a part of their duty to prevent infection from venereal diseases, the alarming increase of these maladies, and their resulting evils, have tended to make prophylactic measures much to be desired.

Dr. Haussmann (*Deutsche Med. Wochens.*, No. 25, 1885), of Berlin, was led from his observations of the efficacy of nitrate of silver in preventing gonorrheal ophthalmia in infants born of women suffering from gonorrhœa, to extend its use to the prevention of the latter disease in men after exposure.

He found that an injection of a two-per-cent solution of nitrate of silver into the urethra, at most a quarter of an hour after cohabitation with an infected woman, has proved a very effectual means of preventing infection. He recommends further investigation into this field, which, although subject to severe criticism from moralists, certainly does present a practical side.

Dr. Martineau recommends (*Bull. de Thérap.*, Nov., 1885) as a prophylactic a solution of bichloride, 1 to 500, to be used as a wash and injection. He advises that the prostitute should have the solution in her room to be used by both parties, both before and after coition. His formula is:

R Hydrarg. bichloridi.....	2 pts.
Ammonii chloridi.....	6 “
Alcohol.....	200 “
Aquæ.....	.ad 1000 “

M.

The application of this solution, while innocuous, is very efficacious in its action upon the gonococcus.

Reviews.

TRANSACTIONS OF THE ACADEMY OF MEDICINE IN IRELAND, VOL. III. Edited by WM. THOMPSON, M.A., F.R.C.S. Dublin: Fannin & Co., 1885.

The transactions of the Academy of Medicine in Ireland for 1885 comprise a large number of valuable contributions which are highly creditable to the scientific research and activity of the members of this body.

Of special interest to dermatologists may be mentioned a paper on “Lupus and its Treatment,” by Dr. Walter G. Smith; “Tar Cancer,” by Dr. C. B. Ball; “Epithelioma of the Eyelid resulting from irritation by crude carbolic acid,” by Mr. J. B. Story; “Sub-Lingual Epithelioma,” by Mr. K. Franks; “On so-called Malignant Growths,” by Mr. George Fry, etc.

Many of the papers are admirably illustrated, and the volume is well printed on good paper, presenting a handsome appearance.

VENEREAL MEMORANDA: A MANUAL FOR STUDENTS AND PRACTITIONERS. By P. A. MORROW, A.M., M.D., etc. New York: William Wood & Co., 1885.

The title of Dr. Morrow's little book does not express the full scope of the author's design. By *Venereal Memoranda*, one might infer that the book was

simply a collection of such elementary facts relating to venereal disease as a student would need to memorize. But the author's aim was evidently more ambitious than this. By epitomizing the materials embodied in the vast literature of the subject, embracing as they do a very great variety of topics and disputed questions, the writer has succeeded in producing a work which has for the practitioner the value of a reference book. The different subjects are presented in a series of short and carefully composed paragraphs that for the most part take the form of aphorisms, a form which seems well adapted to the writer's purpose, but is liable to lead to dogmatism. Of this danger, however, the writer appears to have been fully aware. The labor involved in his undertaking was doubtless much greater than is at once apparent, on account both of the extent of the materials and of the unsettled state of many questions concerned. Considering the nature of the work, the author's judgment and discrimination are entitled to much credit.

Not only can these "Memoranda" be confidently recommended to the undergraduate, but also to the busy practitioner, who would in a convenient form have access to the best accredited views on venereal subjects—views that otherwise he would be obliged to extract by a laborious process from many writings which may not be at hand or which, perhaps, he has no time to consult.

The typography and general appearance of the book leave nothing to be desired.

E. B. B.

Books and Pamphlets Received.

Transactions of the Medical Society of the State of Pennsylvania at its thirty-sixth annual session. 1885, Vol. xvii.

A Case of Multiple Sarcoma of the Skin, by C. A. CHEEVER. Reprint.

Beitrag zur Therapie der Leucoplakia, von DR. JOSEPH.

Pruritus Cutaneous Unilateralis nach Gehirnenbolie. Idem.

Ein Fall von erworbener idiopathischer Atrophie der Haut, von DR. K. TONTIN, in Wiesbaden.

Ueber Saponimente oder Medicinische Opodeldoken, von DR. LETZEL, München.

Del Rinofima, del Prof. PIETRO GAMBERINI.

Syphilis der Trachea und der Bronchien, Pneumonia Syphilitica, von DR. CARL KOPP.

Ueber die Behandlung der Syphilis mit Subcutanen Injectionen von Hydrargyrum formidatum, von DR. CARL KOPP.

Ueber den gegenwärtigen Stand der Lehre von dem Resorptionsvermögen der menschlichen Haut, von DR. C. KOPP.

Ein Fall von multipler Sclerose des Gehirnes und Rückenmarkes in Folge von Syphilis. Die Merkurseife, von DR. SCHUSTER.

Syphilis des Verriers—Falsification des Matières Alimentaires etc. Par E. BESNIER.

Treatment of Lupus by Parasitocides, by JAMES C. WHITE. Reprint.

Angioma Pigmentosum et Atrophicum. Idem. Reprint.

Three cases of Xeroderma Pigmentosum (Kaposi) or Atrophoderma Pigmentosum, by H. RADCLIFFE CROCKER. Reprint.

Items.

THE TREATMENT OF FURUNCLES.—M. Hardy recommends, *Gazette des Hôpitaux*, both local and general treatment. Locally he uses: 1st, poultices of rice flour, or bread and milk, but not linseed meal; and repeated bathing; 2d, maturatives, such as *Onguent de la mère* (composed of olive oil, lard, butter, suet, yellow wax, litharge, and pitch), ungt. digestivum, ungt. styrax, adhesive plaster, or emplastrum hydrarg. de Vigo. He does not open the boils, except when they take a slow course. He believes that there is no use in trying to abort the boil with tincture of iodine, nitrate of silver, etc. For internal medication against the furunculous diathesis, he advises the use of tar water with the meals; oil of cade in pills or capsules; sodæ bicarbonatis ʒi. before meals; alkaline waters, and Fowler's solution. Attention to hygiene is of the most importance.

PRURITUS VULVÆ.—Dr. Julien's formula for pruritus vulvæ is as follows:

℞ Zinci oxidi 25 grams.
 Acidi salicylici..... 1 gram.
 Glycerini amyli..... 25 grams.

M. Sig. Apply as needed.—*Paris letter in Phila. Med. Times.*

FOR IMPOTENCE.—

℞ Ext. cannabis ind..... gr. x.
 Ergotin (aq. extr.)..... ʒ ij.
 Ext. nucis vomica..... gr. x.

Ft. pil. No. xx.

Sig. One morning and evening.—*BARTHOLOW, Col. and Clin. Record.*

A LITTLE LEARNING IS A DANGEROUS THING.—The smart young lady who wrote a note to the doctor, asking him to visit her brother, and bring his urethra with him, has been discounted by a well-informed medical student of Indianapolis, who was asked recently by his sweetheart to examine her throat for some slight ailment. Being anxious to exhibit his embryonic medical talents to his fair'inamorata, he called for a spoon, dexterously depressed her tongue, gazed knowingly into the yawning chasm thus brought into view, and then, with a look of profound wisdom, informed her that *her vulva was greatly elongated.*—*Ind. Med. Journal.*

TREATMENT OF ITCH.—Comessati recommends the following treatment of itch as more simple and successful than any other hitherto used (*Journal de Méd.*, No. 4, 1885): 200 grams (6½ oz.) of hyposulphite of sodium are dissolved in a litre (Oij.) of water, and the entire body, before retiring, is treated with this solution. On the following morning the body is treated with a solution containing 50 grams (2 oz.) of hydrochloric acid in a litre of water. The explanation of this treatment is very simple: sulphur in a state of fine division settles in the pores and remains there for a long time; sulphurous acid and chloride of sodium are also formed. These two results of this reaction are both toxic to the acarus, and the affection is usually cured by a single application.

TURPENTINE IN MALIGNANT TUMORS.—Prof. Vingt, of Barcelona, employs a hypodermic injection consisting of one part of turpentine and two parts of alcohol in carcinoma and sarcoma, and has frequently succeeded in causing these neoplasms to disappear. A local inflammation with fever, lasting about eight days, was the usual consequence of the injection.—*Revista de Ciencias Medicas*, No. 1, 1885.



Dr. Morrow's Case
of
Iodide of Potassium Eruption.

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Original Communications.

THE BULLOUS FORM OF IODIC ERUPTION.¹

BY

PRINCE A. MORROW, A.M., M.D.

Clinical Professor of Venereal Diseases, University of the City of New York, Surgeon to Charity Hospital, etc.

COMPARATIVELY few cases of bullous eruption caused by the ingestion of iodide of potassium are found recorded in the literature of drug eruptions, and it may therefore be classed among the rarer cutaneous manifestations of the drug. A most remarkable case of this eruptive form recently came under my observation at Charity Hospital.

The patient, Albert Stout, a German, about fifty years of age, was transferred to the Dermatological Ward, October 9, 1885. Upon admission the entire face, the ears, and the neck down to the level of the hyoid bone were found to be the seat of an eruption, also the dorsal surface of hands and wrists. The integument of the forehead and face was bright-red and infiltrated to such a degree as to be a quarter of an inch thicker than normal, causing the natural lines of the skin to appear like deep furrows. The skin appeared as if thrown up into prominent bosses or ridges, separated by intervening depressions. The enormous tumefaction of the supra-orbital folds gave a leonine appearance to the face. The eyes were closed from the œdematous condition of the upper and lower lids.

The face, and especially the forehead, was thickly studded with small vesico-pustules, many of which had broken, leaving a mass of crusts. Upon the upper portion of the forehead the fusion of the closely-crowded bullæ had formed a belt or zone of raised epidermis, simulating in appearance the advancing border of an erysipelatous inflammation, which

¹ From a forthcoming work on "Drug Eruptions." Wm. Wood & Co., Pub'rs.

stopped abruptly at the line where the hair began. The dermatitis, both of the face and posterior portion of the neck, did not encroach upon the hairy scalp. The swollen alæ of the nose were covered with a number of pea-sized lesions, some of which had become pustular. The ears were greatly swollen, and where the crusts from ruptured bullæ had been picked off by the patient, bloody crusts were to be seen. The skin became pale on pressure, but did not pit, and immediately resumed its red color when the finger was withdrawn.

Upon the dorsal surface of the hands and wrists, the skin was reddened and infiltrated, though not to the same degree as upon the face. On the dorsum of the left hand, from the wrists to the tips of the fingers, were a number of bullæ varying in size from a three-cent piece to that of a silver dollar.

Upon the right forearm above the wrist there was one large bulla and two smaller ones, with a few vesico-papules. The back of this hand was occupied by a large bulla, the size of a pigeon's egg, surrounded by a number of smaller ones, suggesting in their arrangement a magnified herpes iris; toward the ulnar or outer border were four or five bullæ, ranging in size from a large pea to that of a cherry; the second, third, and little fingers were occupied by bullæ extending along their entire length to the tips, the walls tensely distended with a sero-sanguinolent secretion. Both hands presented a swollen, puffy appearance. There was no eruption upon any other portion of the body. Examination of the mouth and fauces revealed nothing beyond an intense congestion of the mucous membrane. The patient was in a state of profound prostration; he was dull and stupid and could be aroused with difficulty: there was more or less tremor of the hands, and he was constantly moving them toward his face. His respiration was quickened and his pulse was 120, temperature not taken.

In the presence of a case presenting eruptive features of such unusual intensity and development, and which could not be identified with any of the ordinary dermatoses, I made the diagnosis of "iodide of potassium eruption," although it was not known at the time that the patient had been taking the drug.

Upon making my visit the next day, I was furnished with a history of the patient previous to his transfer to my ward, which my House Surgeon, Dr. A. Talbot, had procured from the records of the Nervous Hospital. I am also indebted to him for the notes, from which the subsequent history of the case is condensed.

"The patient was admitted to the Nervous Hospital (Par. O. & P. Depart.) on Sept. 23, suffering from incomplete paraplegia. There was no history of syphilis or of any skin disease except rosacea, evidences of which were present in the shape of a slight acneiform eruption. The patient was ordered a solution of iodide of potassium (1 in 2) 3 i., t. i. d. This was stopped on Oct. 4, after he had taken 900 grs. altogether. Three or four days after beginning the use of the iodide there was observed an erythematous condition of the face, with the production of vesico-pustules about the size of a small pea. About October 1, an eruption appeared upon the backs of the hands. Under the continued influence of

the medicine the dermatitis increased in intensity and severity, and the vesicles developed into bullæ of varying size. The iodide was discontinued Oct. 4, and for four days the patient was given pills of *calcii sulphidi* $\text{aa } \frac{1}{2}$ gr., one three times a day."

Oct. 10. The general appearance of the condition upon the face was about the same as yesterday. The bullæ upon one hand had become coherent at their bases, but did not coalesce. Upon the other hand the lesions had become confluent, forming an enormous blebs extending from the annular ligament of the wrist to the tips of the fingers. The color was a steely blue, bearing a striking resemblance to the appearance of a coil of intestine. The general condition of the patient unchanged; resp. 23, pulse 112. Catheter will not pass on account of stricture at $4\frac{1}{2}$ inches, admitting No. 10 sound with difficulty. Urine duck kept in bed with patient. He was placed upon an extra diet and ordered whiskey $\frac{3}{4}$ iv. per diem. The face and hands to be dressed with carbolized vaseline. Some of the bullæ were punctured, yielding a reddish serum which was examined for iodine with negative results.

Oct. 11. No change in appearance except that some of the older bullæ on hands have become dirty-blue in color, and on puncture give exit to a dirty-red sero-pus instead of a clear serum as before. Examination of heart showed a systolic apex murmur transmitted toward left axilla. Diagnosis of mitral insufficiency. Temperature, 100.1° ; resp., 22; pulse, 114.

Oct. 12. Infiltration of the skin has subsided somewhat; examination of the urine shows it acid in reaction, sp. gr. 1.010, with a considerable amount of albumin, 10 to 15 per cent. Under the microscope a few pus and blood globules are seen; no casts.

Oct. 14. On the back of the neck the skin has returned to its normal level, but is still red, the face less swollen, eyes well open and bright in appearance, leonine appearance of countenance gone. The bullæ on hand present a blue-black coloration. A bloody pus, slightly offensive, comes from one or two ruptured bullæ. All the bullæ were ordered to be cut open, washed out with $2\frac{1}{2}$ -per-cent carbolic solution, and dressed with carbolized vaseline. The floor of some of the bullæ is bathed in pus, apparently due to superficial ulceration.

Oct. 21. Continued improvement in general condition of patient, the backs of the hands cleared off and presenting a healthy appearance.

Oct. 29. The skin of the neck and a good part of the face has returned to its normal conditions, though still somewhat hyperæmic. Raw surfaces on dorsum of hands and fingers healing.

Nov. 5. Almost all traces of the eruption gone, though no gain in the patient's general condition. Patient has cough. Examination of chest shows dulness at apices of both lungs, with increased fremitus, prolonged high respiratory murmur, and few moist râles. Passes urine and fæces in bed as on entrance.

Nov. 15. Patient has continued to fail. Increasing frequency and feebleness of pulse (120); resp. 32. Examination of chest shows pulmonary œdema.

Nov. 16. Patient died quietly at 2 A.M.

Autopsy showed heart enlarged and dilated on left side. Insufficiency of mitral valve and atheromatous deposits. Aorta atheromatous. Lungs œdematous; phthisical consolidation at both apices; no cavities. Kid-

neys somewhat diminished in size and heightened in color ; consistence increased ; surface granular ; capsule adherent. *Liver* and *spleen* normal.

The drawing representing the face in the accompanying picture was made on the second day after the admission of the patient, when the more acute eruptive features had begun to subside. A photograph from which the drawing of the hands was made was taken after some of the bullæ had ruptured and partially collapsed. The direct dependence of the eruption upon the iodide of potassium in this case would seem to be conclusively established ; first, by the appearance of the cutaneous phenomena within three or four days after commencing the use of the drug ; second, by the intensification of all the eruptive features under its continued use ; third, by the subsidence of the eruption soon after the drug was withdrawn, and, fourth, negatively, by the absence of any other known exciting cause.

It will be observed that while the iodide was discontinued on October 4, the eruption did not attain its maximum development until four or five days later. Whether the sulphide of calcium, given in the interim, exerted any material influence in intensifying and perpetuating the eruptive tendency is open to question. Such an assumption is, however, unnecessary in explanation of the continued development of the cutaneous disorder, since it is well known that a morbid process set up in an organ may continue after the exciting cause has ceased to act. In this case it is probable that, owing to the impairment of the integrity of the kidneys, through which iodine is principally eliminated, the drug accumulated in the system and continued to produce its toxic effect upon the blood and nerve centres for some days after its introduction. It is a well-attested clinical fact that many of the severer forms of iodic eruption occur in patients who are found to be suffering from renal inadequacy and cardiac lesions. Whether the cardiac complications stand in the relation of a determining cause or a mere coincidence has not been definitely determined.

The comparatively slow involution of the lesions in this case was probably due to the profound systemic depression caused by the drug, and the existence of the grave organic troubles which ultimately proved fatal.

66 W. 40TH STREET.

ON THE LIMITATION OF THE CONTAGIOUS STAGE OF SYPHILIS,
ESPECIALLY IN ITS RELATIONS TO MARRIAGE.¹

BY

FESSENDEN N. OTIS, M.D.,

Clinical Professor of Venereal Diseases in the College of Physicians and Surgeons, New York.
(Concluded from p. 72.)

IN the recent important work on Syphilis and Marriage, published by M. Alfred Fournier, of Paris, in 1880, for the purpose of justifying his statements that "*syphilis is but a temporary bar to marriage*," previously quoted, has presented a series of eighty-seven examples, occurring in his own experience. In presenting the carefully tabulated report of these cases, he says: "For my part alone, I have in my hands, to speak only of written facts, eighty-seven observations relative to syphilitic subjects, undoubtedly syphilitic, who, having married, have never communicated to their wives the least suspicious phenomenon; and, moreover, these 87 have produced among them a total of 156 absolutely healthy children. In examining the tabulated records of these 87 cases at page 231 et seq. of his work (Fournier, "*Syphilis et Marriage*"), I found that 36 out of this number of men, who were thus proven to be free from any power to transmit syphilis, either by direct contact or by heredity, were subjects of late or tertiary lesions *after marriage*, some before, and some after the birth of the children.

These lesions comprise almost all the varieties of the sequelæ of syphilis, thus: gumma of the penis, palmar psoriasis, dry tubercular syphilide, gumma of velum palati, cerebral syphilis, papulo-tubercular syphilide, costal periostitis, cerebro-spinal symptoms, evidently of syphilitic origin, diplopia, passing attacks of hemiplegia, nasal syphilides, ecthyma of legs, syphilitic sarcocele, nasal ulcers, ulcerative laryngitis, papulo-squamous palmar and plantar syphilides, sclerous glossitis, papulo-scaly syphilides of circinate form, tubercular ulceration, syphilide of the nose, etc.

In examining the tables of M. Fournier still further, it was found that the average time of marriage, after infection, in the eighty-seven cases, was $5\frac{8}{10}$ years; that twenty-five per cent were married within three years after infection, and over ten per cent within two years.

In regard to the length and quality of treatment, over twelve per cent of the eighty-seven cases had treatment of less than a year's duration; several with only a few months, one with the iodide of potash, and another with no treatment at all.

¹ Read at the Annual Meeting of the New York State Medical Society, Feb. 5, 1886.

In this enormous mass of evidence, consisting of eighty-seven authentic examples, involving prolonged observation of two hundred and thirty individuals, adduced by an acute, thorough, and competent observer, we have what I shall claim as absolute truth: first, of the non-contagiousness of all lesions of the tertiary stage of syphilis; second, of the possibility of the spontaneous cure of the contagious stage of syphilis (*i. e.*, without treatment), as shown in one case, where there was no treatment, and in another case, where only the iodide of potash was used. Third, that the limit of the contagious stage in syphilis, may then, it seems to me, be certainly fixed at a point within the period of five years.

For my own part, I have *never* seen a case of syphilis presenting an undoubted lesion of the secondary or active stage after the termination of the second year. I have seen a goodly number of cases of recurring papular syphilide—especially upon the hands and feet, occasionally upon the body—two and three years after an infection which had been thoroughly and systematically treated from the beginning, and I have always considered them as due to damage done to the lymph channels, during the previous active stage of syphilis. After the third year, in three such cases, marriage has been entered into, with my consent; and in two, recurrences in the identical places formerly occupied took place nearly a year after marriage, and in both these cases, the wife remained uninfected, and healthy children were reported, one now three, and the other two years old. I have seen frequent lesions of the tongue, from two to a dozen years after infection, the sequel of mucous patches occurring during the active stage, which had been asserted, by physicians, to be mucous patches, and capable of transmitting syphilis. Sometimes those would present simply as pale pearly stains, or whitish patches, sometimes erosions and ulcerations, and cracks again appearing as irregular spots covered with a white or grayish pellicle with more or less induration. Such lesions I have never known to prove a source of syphilis to others, although coming into most intimate contact, such as between man and wife, for a series of years, during which recurrences had taken place. Hence I do not hesitate to state, that such forms of trouble, occurring as a sequel of syphilis, three years or more after infection, do not contain the contagious property of syphilis, and hence cannot communicate it. I have also seen numerous cases and observed them during long periods, in which marriage has taken place from three to twelve or more years after a syphilitic infection of the father, and I have never yet seen a single symptom of syphilis in the wife or in the children born of such marriage. In the reported cases where syphilis has been claimed to have been contracted from persons whose syphilis had its initiation three or more years previously, I believe that, if the truth could be ascertained, it would be shown that the disease was *not* contracted from such persons, but al-

ways from a source less than three years from date of the infection. The overwhelming evidence, as to the improbability of the communication of syphilis, after the first three or four years from the date of infection, as shown by the statistics of M. Fournier, should lead to the greatest opposition in accepting cases alleged where syphilis has been acquired in contradiction of this position. The traditions of syphilis claim, that once a man has had syphilis he is a possible focus of contagion forever, and any evidence that a man has once had syphilis, is held as competent to prove that any syphilitic accident in his family, to the latest generation, may be reasonably credited to him. The important fact that syphilis may be communicated through other sources, is practically ignored. Syphilis from mediate contagion is common. It may be through the medium of a spoon, a pencil, a cane, a cigar, a kiss, the dentist's instruments. The accoucheur may acquire it through his finger. Nine cases of syphilis of the finger I published several years since as occurring under my own observation, and I have seen others since that time. Besides this, I have seen at least double that number of cases of syphilis, where no possible trace of the source of contagion could be ascertained. A tumbler, or any article in common use, defiled with the secretions of a mouth harboring a mucous patch coming in contact with a crack or abrasion of the lips of a healthy person may communicate syphilis through a resulting lesion which may pass away unnoticed. Any similar contact with the blood of a person in the active stage of syphilis will communicate it. And yet, if the resulting syphilis is not distinctly traced to some one of these sources, the disease, where possible, is referred to some person who has had syphilis, perhaps a quarter of a century before. It is the *tradition*, based upon the everlasting contagious nature of the disease, that the profession are wont to fall back upon to explain the mystery. Even M. Fournier is not free from the tyranny of this unproven tradition. Notwithstanding the convictions that his intelligent experience has imbued him with, that syphilis is not communicated by any person after the first three or four years from infection, and which impel him to state that *syphilis is but a temporary bar to marriage*, and which makes him say, "Yes, a hundred times yes, a man may marry after having had the pox, and the result of such a marriage, under these conditions, may be absolutely safe, medically speaking," yet, Fournier subsequently says: "We must still recognize some rare exceptions where the disease retains its contagious properties indefinitely. Such, for example, is the case of a patient whom I treated some time ago. This young man had been infected with a syphilis five years before, which one could fairly call mild, since the initial chancre was only followed by a roseola, a palmar syphilide of slight intensity, and a sore throat. He treated it almost from the beginning sufficiently well; several times he

submitted, under my advice, to a strong mercurialization (fifteen to twenty centigrammes of proto-iodide daily). Well, in spite of this treatment, and in spite of all my efforts, the patient (who, by the way, is a smoker, a circumstance essential to note) has not ceased to be affected, during a period of five years, with lingual syphilides almost continuously. I cured him of one breaking out; one or two months later a new one attacked the tongue; then came a new treatment, followed by a new cure; then reappearance of the malady, and so on. To be brief, I always cured him, and it always began again, to use his own expression. Now that he has completely given up tobacco at my earnest solicitation, the eruptions become less frequent, but have not altogether ceased; and quite lately I have again seen him with syphilis coming on the back part of his tongue. Now, what would have happened if, relying on the mild nature of his disease, and satisfied as to the treatment followed, I had allowed the patient to marry between the two outbreaks of such symptoms? What would have happened, I need not predict theoretically, because I have had a practical demonstration. This young man took as a mistress last year—a woman who, till then, was perfectly healthy, exempt from every venereal symptom. Some weeks later he brought her to me, affected by an indurated labial chancre, manifestly received from the lingual syphilides of the patient.”

This case, and the only case, is presented as a typical one, to illustrate the possible persistence of contagious lesions after many years, notwithstanding the disease is of mild form, and has been systematically, persistently, and efficiently treated “almost from the beginning.”

Now, is such a conclusion sufficiently warranted by this evidence on a matter of such moment? Let us look at other causes, equally possible, equally probable. The young man did not take for a mistress a woman whose virtue was above suspicion. Such a coincidence as the contact of such a woman's lip with some other lip, with fresher syphilitic lesions, would not be so extraordinary as the acquirement of syphilis from a buccal lesion five years after infection. Such a woman would be quite in line of coming in contact with persons having active syphilis, and either directly or by mediate contagion might have acquired her labial chancre, even if she had not become this man's mistress, without exciting especial comment.

Let me place here in contrast to this, a case taken from my own experience. A young man had undoubted syphilis; from the first under my own observation: characteristic initial lesion, general gland enlargement, roseola, no pronounced papular eruption, mucous patches on tongue and inner surface of feet. After a somewhat desultory treatment of two years, he was apparently well. Remained free from all trouble for two years; then began to have ulceration at the side of the tongue, pearl-

colored at edges, characteristic appearance of the so-called chronic mucous patch; was greatly addicted to tobacco, tongue resisted local treatment, unless accompanied by exclusion of tobacco; repeated recurrences for nearly five years; not markedly affected by specific treatment, which was tried from time to time, when at last he married a virtuous girl. Since that time already four years have elapsed, and the wife has not yet had a symptom of syphilis. As a result of this marriage, there is to-day a perfectly healthy child three years old, and yet within the last month the husband consulted me in regard to a recurrence of the ulceration at the border of the tongue.

M. Fournier ignores entirely the possibility of accounting for the initial lesion of the lip, in the rare case he quotes, in any way except through the chronic lesion, which his history has shown chiefly to be dependent for the difficulty of cure, on the use of tobacco. This one case is placed, squarely, as an offset against his eighty-seven cases, some of which were also cases of ulceration of the tongue, incontestably proved to be free from the contagious element of syphilis by the immunity from infection of the eighty-seven wives and one hundred and sixty-seven children involved. It is true he brings forward a few cases in the practice of other physicians to prove the possible inoculability of late lesions of syphilis, but those, in the face of such statistics as he has given us, are not to be accepted while they are all open to explanation in various reasonable ways, independently of the claim of a contagious element persisting for years from the date of infection. We cannot allow even such an authority as M. Fournier, to force the acceptance, without question, of a conclusion in such direct antagonism with the mass of positive and conclusive evidence that he has given us, of the non-inoculability of the late lesions of syphilis. We are, I assume, fully warranted in claiming, that the explanation of the only case which he brings up directly to prove that the late lesions of syphilis may, in exceptional cases, be contagious, undoubtedly lies in the acquirement of syphilis from a source quite independent of the five-years-old lingual lesions to which he hastily attributed it. Eliminating this case, we have then, a solid mass of evidence, which, on any other point, would be absolutely conclusive. In support of this, we have also the failure of all experimental inoculations with the secretions of the late lesions of syphilis, which have been failures in every instance. We have also the knowledge of some of the various occult ways in which syphilis may be acquired, defying absolute demonstration. In the absence of an old syphilis in the husband, we have various ways of accounting for repeated abortions and pemphigoid infants, upon which rest the diagnosis of syphilis as a cause, when such syphilitic history in the male parent might have been accepted before we knew that the semen did not contain the contagion of syphilis. The great discussion in the Academy of Medicine in Paris, a *résumé* of

which is given by Diday (page 72 of his work on "Infantile Syphilis"), shows that the conclusion was arrived at that "Pemphigus of the fœtus was not an immediate result of syphilis, but an indirect sequel of the exhaustion which this disease produces."

It is true that abortions, and the production of diseased infants, may continue long after the active or contagious stage of syphilis has passed. It seems to me, however, that it is not too much to claim, that this continuance is due to changes produced in the reproductive organs of the female during the early stage of the disease, and should be classed among the sequelæ, which have been proven to be free from the contagious element of syphilis.

With this presentation of some of the facts and arguments which may be brought to bear in favor of a positive limitation of the contagious stage of syphilis to three and at farthest to four years, with or without treatment, I rest my case.

No. 5 West 50th Street.

A CONTRIBUTION TO OUR KNOWLEDGE OF THE HYDROA BULLEUX OF BAZIN, AND OF THE DERMATITIS HERPETIFORMIS OF DUHRING.¹

BY

R. W. TAYLOR, M.D.,

Surgeon to Charity Hospital.

I DESIRE to present to the Society this evening the history of a case of skin disease which, in my experience, is very rare, and which is of much interest in its pathological and nosological relations, as well as bearing upon its nomenclature.

The following history was kindly drawn up for me by my assistant, Dr. C. W. Cutler.

T. Bush, æt. 29, laborer, Ireland, admitted to Bellevue Hospital, July 14, 1883.

Previous History.—The patient had always been a hard drinker, but, until the present illness, has never been sick, except with an occasional attack of articular rheumatism, which has not, however, been severe enough to prevent his working. Two months before admission, he began to suffer from dyspnœa, which at first only troubled him on exertion, but lately has become so severe as to prevent his working, and accompanied with great dizziness and palpitation of the heart; he therefore applied to the hospital for admission.

On Admission.—Patient cyanotic, and has severe dyspnœa and

¹ Read before the New York Dermatological Society, Jan. 26, 1886.

cough. Pulse rapid, intermittent, and irregular. Slight œdema of the feet.

On Examination.—Heart hypertrophied, valve sounds indistinct and accompanied with a double aortic and mitral regurgitant murmurs. Lungs—Moist râles over both lungs, especially behind (œdema). Urine contains about 5% albumin, not examined for casts. Temperature $99\frac{1}{2}^{\circ}$.

July 16.—Patient's condition remains about the same. Bowels constipated. Appetite fair. Urine small in amount. Temp. $99\frac{1}{2}^{\circ}$.

July 18.—Patient is slightly delirious at night, but quieted with bromide. To-day an herpetic eruption appeared on the neck, behind the ears, causing the patient much burning pain and smarting. Temp. 100° .

July 19.—The eruption has extended, covering the face, neck, and ears. It appears vesicular in character, confluent in patches, and uniting in spots to form large bullæ. A few such spots have made their appearance on the backs of both hands and wrists, but the remainder of the body is entirely free from eruption, as is the scalp. The patient complains much of the heat and pain accompanying the eruption. He is quite delirious, has severe dyspnœa, and was quieted only with opiates. Temp. remains at 101° .

July 21.—Eruption has not extended, but is more confluent, is vesicular and bullous in character. Some of these lesions bursting, and secreting a thick, milky-white fluid, which, drying, forms a yellowish scab. The spots making their appearance last are still vesicular, filled with a clear serous fluid, which is gradually turning turbid and milky.

The spots are not surrounded by much redness, but the face is much swollen and disfigured, the eyes being nearly closed, the patient having the general appearance of one suffering from confluent small-pox. No eruption on the mucous membrane of mouth or on the conjunctiva. Dr. R. W. Taylor was called in consultation, and diagnosed the eruption as of vesiculo-bullous character, or hydroa bulleux. Temp. still remains about 101° .

July 23.—Eruption is slowly drying, forming brownish scabs. Face less swollen. Patient feels much better, eats and sleeps well. Temp. normal. Some dyspnœa.

July 25.—Dyspnœa very severe, patient being obliged to sit up in bed to breathe, and is passing but a small amount of urine.

July 29.—The scabbing process is nearly complete, many of the crusts having fallen off, and without leaving a scab. Patient stronger, but suffers greatly from dyspnœa.

August 1.—The face and neck have assumed a nearly natural appearance, the scabs having fallen off, leaving the skin red but not scarred. Patient's general condition very poor, is delirious most of the time, passing but little urine, with a large per cent of albumin. Pulse weak and rapid. Temp. 101° .

August 3.—Patient died of failure of heart's action.

Here then is a case of a man addicted to alcoholics, suffering from Bright's disease, mitral and aortic lesions with œdema of the lungs, who is admitted to the hospital on the 14th of July, cyanotic to a moderate extent, suffering from dyspnœa and cough, and being slightly anasarcaous. He remains in this condition with a temperature of $99\frac{1}{2}^{\circ}$, until the fourth

day, July 18th, when his temperature rises to 100, and an eruption appears behind his right ear. This eruption presents the appearance of typical herpes, a red inflamed base sharply defined, upon which is seated a large number of vesicles containing clear serum, accompanied by a severe smarting and burning pain. In the evening he became delirious. Neither before his entrance into the hospital had he taken any but simple remedies, certainly no drug whose ingestion is followed by a rash. Within twenty-four hours the eruption covered the face and neck, being everywhere at its invasion vesicular in character and quickly developing into bullæ, some prominent and rather larger than a pea, and others broad and flat, as shown in the picture. On the second day, a few vesicles appeared on the back of the hands, seated on a red and sharply limited base; these increased in number and size, and involved the backs of the hands chiefly as far as the wrist. The heat and pain of the eruption which, at its height, was limited to its face and neck, leaving the scalp intact, and also to the hands, was very distressing. The dyspnœa and delirium were severe, and were only quieted by opiates. Temperature was 101° Fah. On the third day, the eruption was at its height, and so much did the case appear like one of confluent small-pox that Dr. Janeway, the attending physician, suggested to the house physicians, Dr. Cutler and J. H. Frankenberg, to ask me to see it. I need here elaborate but little over Dr. Cutler's description. The face was very much swollen and disfigured, the eyes being closed. The integument was highly inflamed, much thickened and œdematous, and almost completely covered with large vesicles and bullæ. In the centre of the forehead these lesions were less numerous, and while the whole surface was hyperæmic, that on which individual vesicles and bullæ were seated, was thickened and markedly red. At the periphery of the eruption, below the clavicles and over the sternum, the redness and swelling of the skin ended abruptly as a general expanse, but there were a few outlying vesicles and bullæ surrounded by a deep-red and sharply marked areola. The history of the case, the clearly marked vesiculo-bullous character of the eruption, and absence of all shotty papules and pustules, its inception behind the ears, its limitation to the face, neck, and hands, clearly proved to my mind that it was not variola, while the striking features of its history proved it to be vesicular in character and allied in its nature to herpes. For want of a better name I diagnosticated the case as one of hydroa bulleux of Bazin. Though I had long been familiar with cases which accorded with the description given by Bazin of these vesiculo-bullous eruptions, I had never seen it attended with the acuteness and severity of the present case.¹ Bazin says that hydroa bulleux (pemphigus à petites bulles) is an arthritic affection, generally little known. It is

¹ "Leçons Théoriques et Cliniques sur les affect. de la peau." Paris, 1862.

sometimes preceded by loss of appetite and febrile movement. Its sole constant prodromic phenomenon is intense pruritus. The eruption manifests itself by bullæ, whose important character is their one quality of volume, rarely being larger than a pea. They are round, seated in an irregular manner, filled by a transparent fluid which rapidly becomes opaque, even yellowish. They are seated on a red base, with slight areola. They rupture and desiccate, and form yellowish crusts. The course of the disease is chronic, and attended with successive outbursts. It is more frequent in males than in females, occurring between the ages of twenty and forty years. Temperature has marked influence on its development. He has seen it mostly in spring-time. This affection was also considered in editorials in the *British Med. Journal*, May 14, 1870, which was then under the editorship of Mr. Jonathan Hutchinson, the description, which was based on personal observation, being similar to that of Bazin. At this date we were also familiar with the cases described by Wilson as herpes circinatus bullosus, pemphigus pruriginæux by Hardy, herpes gestationis by Milton, Bulkley, and others, the pemphigus aigu pruriginosus of Chaussit, pemphigus composé of Devergie, pemphigus circinatus of Rayer, the herpes phlyctænodes of Gibert, the pemphigus of Klein, and the impetigo herpetiformis of Hebra. While I was convinced that the affection in the case now under consideration belonged to the great family of which these variously described cases were examples, I had recourse to Bazin's name as being the one most applicable and expressive. Yet in many particulars the history of my case differs from those of the other observers.

My friend, Dr. Duhring, has recently written a series of eleven able and exhaustive papers upon what have generally passed as anomalous cases of erythema, eczema, herpes, and pemphigus, and has done, it must be confessed, much good work in simplifying our knowledge and grouping into definite varieties cases which up to his time had been scattered unclassified in journals and text-books. All of these cases Duhring claims belong to one great family, to which he gives the name dermatitis herpetiformis, and of which he makes the following subdivisions: erythematous, vesicular, bullous, and pustular. In describing the different forms I think he makes his case out quite clearly, except as to the first or erythematous form, which he does not clearly and sharply diagnose from erythema multiforme.¹ In the light of Duhring's studies, the case I here consider would be called dermatitis herpetiformis bullosa, under which subdivision he groups all the cases I have mentioned as reported by Wilson, Hardy, Bazin, Milton, Charcot, Devergie, Rayer, Gi-

¹ "Relation of Herpes Gestationis and certain other forms of Disease to Dermatitis Herpetiformis," *Medical News*, Oct. 17, 1885. In this paper will be found a bibliography of all of Duhring's papers upon this subject.

bert, Hebra, and Klein, and still further the cases of B. Thompson, Liveing, Cottle, Gale, W. G. Smith, Jarisch, and Myer.

While I agree with Duhring in most of his clinical conclusions as to this vast family of disease, I am not prepared as yet to accept the application he gives it. In my judgment, his nomenclature requires further extended study, observation, and discussion. In his original paper,¹ Duhring, by implication rather than by direct statement, divides this protean disease into two varieties—mild and severe. He says: "In severe cases, prodromata are usually present for several days preceding the cutaneous outbreak, consisting of malaise, constipation, febrile disturbance, chilliness, heat, or alternate hot and cold sensations. Itching is also generally present for several days before any sign of efflorescence. Even in mild cases, slight systemic disorder may precede or exist with the outbreak. It will be noted that the descriptions of Bazin and Duhring of the affection under consideration do not clearly bring out such a marked and severe clinical picture as is shown by my case. Indeed, in looking through the literature very carefully, I have been unable to find a case precisely analogous. Under the title "*Ueber die Coincidenz von Erkrankungen der Haut und der grauen Achse des Rückenmarkes*," Jarisch² describes a case of which the following is a brief summary:

A married woman, aged 61 years, had in 1874 scattered bullæ upon the arms and face, which subsided spontaneously, the woman thereafter being troubled with redness of the parts affected. In 1877 she had inflammation of the lungs, and other minor troubles. In 1879 she had a copious, symmetrically distributed vesicular pustulous and bullous eruption, almost confined to the upper half of the body, including head and arms. The skin of the face and scalp was much swollen, very red, and covered with crusts and bullæ, grouped or isolated, and seated on a bluish base. On the arms and forearms were small papules and vesicles, and large and small bullæ. Upon the thorax severe dermatitis, with pustules, and sero-purulent elevations of the epidermis was present. A vast hemorrhagic bulla occupied the soles of the feet. The mucous membrane of the tongue was dry, and the mouth reddened, swollen, and in patches excoriated. Excepting swelling of the spleen, nothing abnormal was found on physical examination. The urine was albuminous and loaded with urates. The patient was weak and debilitated, and had marked fever. In a few days the eruption disappeared, leaving scales, crusts, and brownish pigmentation. In the following month new eruptions appeared, followed by bed-sores, abscess, and death. At the autopsy Bright's disease in the third stage, lobular pneumonia, and sclerosis of the gray columns of the cord from the third cervical to the eighth dorsal vertebræ. The skin affection began at the vertex, and ended about the umbilicus.

Duhring also quotes this case, and says that "it has sufficient points

¹ "Dermatitis Herpetiformis," *Journal of the American Medical Association*, August 30, 1884.

² *Vierteljahrs. für Derm. und Syphilis*, vol. 12, 1880, page 195.

in common with dermatitis to warrant its being classed here rather than elsewhere." Myer,¹ of Strassburg, reports the following case as one of a fatal pemphigus-like dermatitis, with changes in the nervous system. It was of a woman, sixty-five years old, previously healthy, in whom what was regarded as a diffuse eczema of the papular, vesicular, and rubrum varieties appeared without systemic reaction. In its fourth week large bullæ appeared on the buttocks and legs, together with grave symptoms of constitutional disturbance, which increased, and culminated in death, the disease having run its course in seven weeks. Duhring also quotes this case as one of dermatitis herpetiformis, and I thus briefly include it in this paper as being in some measure similar to mine. It is to be hoped that we shall hear from other observers who may have seen similar cases, so that later on our knowledge of this grave form of cutaneous affections may be more precise and extended.

I may here add that I saw with my friend, Dr. P. A. Morrow, at Charity Hospital, a case of which the clinical features, to my mind, pointed clearly to the diagnosis of hydroa bulleux of Bazin, or the dermatitis herpetiformis of Duhring.

ON THE EXISTENCE OF "DERMATITIS HERPETIFORMIS" (OF DUHRING) AS A DISTINCT DISEASE.²

BY

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AMONG the many and varied lesions which may occur upon the skin in disease, curious and anomalous conditions are met with from time to time, rarely, it is true, which cannot with certainty be at once relegated to any one of the many well recognized maladies to which this great organ is subject; occasionally even a most patient and prolonged study of a case will not serve to give to it any one of the names ordinarily applied to diseases of the skin. Gradually peculiar cases, exhibiting similar features, previously un-noted, will be collected and analyzed, and from a study of them a description may be made which will serve to identify other instances of the same description, until at length such cases are recognized as belonging to a particular disease, with its name, pathology, etiology, and treatment. Thus it is that Dr. Duhring

¹ Archiv für Path. Anat. und Phys., Nov., 1883, page 185.

² Read before the New York Dermatological Society, February 23, 1886.

has endeavored to group together certain cases which had previously received various and uncertain names, under a single designation, "dermatitis herpetiformis," which he describes as a distinct disease, exhibiting many and different phases, still closely related to each other. How far he is warranted in the position taken remains to be seen, and forms the subject of our discussion this evening.

The following history of the patient exhibited at the last meeting of this Society illustrates and will serve to introduce the subject under consideration :

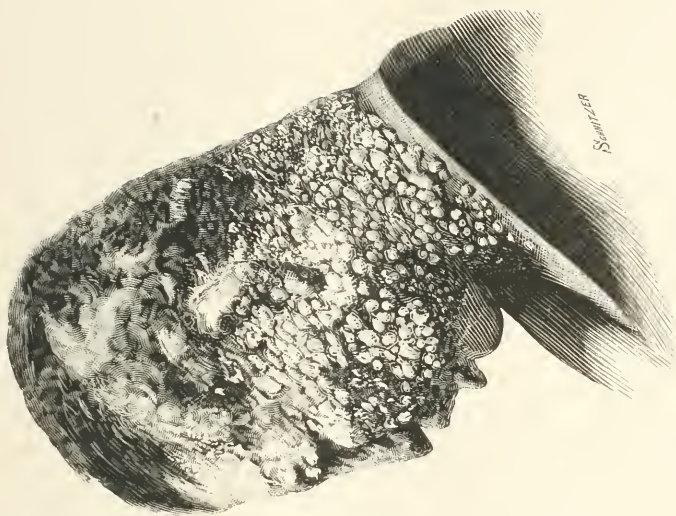
Alfred S., aged 24, a blacksmith, of muscular build and very intelligent, presented himself at my clinic at the New York Hospital, November 25, 1885, suffering from a chronic, universal, multiform, and intensely itching eruption, and gave the following history.

His parents, who were Irish, came to this country in 1850 ; a number of his mother's family and his cousins died of phthisis, and his father died of the same complaint ; his mother is living and healthy. One brother, who died at twenty-four, was exceedingly nervous and irritable, having strange attacks, almost of temporary insanity. The patient has chewed tobacco excessively since he was nine years old, and also drank very heavily from eighteen to twenty years of age. When thirteen years old he began to masturbate, and practised this excessively until sixteen years of age, and probably later. He worked in a blacksmith shop from fifteen to seventeen, and then took up rag-carpet weaving for three years, after which he returned to blacksmithing.

The eruption first appeared in the summer, five years ago, when he was nineteen years of age, and has continued, almost without interruption—that is, with periods of improvement and relapse—up to the present time. It began during the period when he was working very hard, for nearly twelve hours a day, at carpet-weaving, and while he was chewing a paper of tobacco daily and drinking heavily, both in the daytime and during the evening. It may be mentioned that his work was done in a sitting posture, with both legs and arms actively engaged.

The first symptoms of his disease consisted of intense itching, with the sudden development of successive crops of what he described as "white pimples," apparently vesico-papules, present over much of the surface, except the head, which has been involved only within the past year. During the hot weather, when the eruption first appeared, the patient perspired profusely across the chest, and affirms that his undershirt was always stained a peculiar greenish color by the perspiration ; this phenomenon he had never observed before or since.

The eruption has generally been somewhat worse in the summer time. While it has affected at times most of the surface of the body and limbs, it has appeared most profusely upon the buttocks and the lower abdomen and groins, extending even upon the penis. The patient has himself remarked the multiform character of the eruption, it often changing its form to boils and abscesses, as he says, and at other times presenting ulcerations, the result of scratched lesions. The itching has always been most intense during the day, and to relieve this he at one time took considerable liquor, which seemed to have a temporary benumbing effect ; beer was always found to have a worse after-effect than spirits. He had



Dr. Taylor's Case of Hydroa Bulleux.

tried the greatest variety of treatment, but all with only temporary, if any, benefit.

When first seen (November 25, 1885), both forearms and elbows were covered with small, shining papules, a few of them showing vesiculation, from which a drop of clear serum could be squeezed. The thighs were thickly sprinkled with reddish blotches of various sizes, some over half an inch in diameter, many of them not elevated above the skin, and representing only pigmented stains, while others were more or less elevated and represented the remains of the inflammatory bases and areolæ of former pustules. The loins and buttocks were also the seat of eruption, presenting flat, adherent crusts on slightly inflammatory bases. There were also remains of eruption on the back, and some few lesions on the lower legs, and some superficial scars of various sizes and shapes, slightly depressed and sharply defined, scattered over various portions. His general condition was good, he was well nourished, and the flesh firm; he was habitually constipated. He was given a laxative pill, an alkaline tonic, and an antipruritic lotion.

December 2. The itching has been slightly allayed, but the eruption is worse. Crops of superficial pustules have appeared over the limbs, and also in the lumbar region; inguinal adenopathy exists.

December 9. Over the upper part of the right scapula a patch of eruption has appeared, strongly suggestive of herpes zoster. The group is irregular in shape, an inch and one-quarter in diameter, and composed of papulo-vesicles, with a few much smaller clusters and isolated papules. A somewhat similar eruption has also appeared upon the scalp. The lesions are attended with much itching. The patient was directed to cease the use of tobacco, which he was quite willing to do, as he had become much demoralized by his disease. He was given an acid, iron, and magnesia mixture, with the addition of strychnia.

December 23. Fresh eruption has again occurred, now in the form of pustules, upon the arms and in the axillæ, and upon the legs.

January 2, 1886. Again a fresh outbreak, this time mainly on the calves, in the form of large, ecthyma-like pustules, in moderate number, and evenly distributed.

January 20. The patient has still fresh lesions developing upon the loins, buttocks, thighs, and elsewhere. They are now in the form of large, flat, rather flabby vesicles or bullæ, containing a whitish, turbid or purulent serum; these are evidently the lesions which gave rise to the flattened, adherent crusts already mentioned.

Since the last date the patient has continued under observation and treatment, with no material change in his condition, except the continued production of the lesions from time to time, together with great itching. The last phase of the eruption was in patches, over the scapulæ, mainly of erythematous appearance, varying in size from one-half to one and a half inches in diameter, with grouped vesico-papules upon them.

Did time permit I should like to detail some other somewhat similar cases, more or less illustrative of our subject, but must now content myself with this for my text.

The question now arises, What name should be given to the disease in such a case, and where should it be classed? It presented many lesions—

papules, vesicles, blebs, pustules, and erythematous patches—was accompanied with great itching and persisted for five years, apparently yielding to no treatment, but exhibiting exacerbations with marvellous facility. The vesicular and bullous lesions might place it with eczema, herpes, or pemphigus—but no one familiar with the ordinary types of these affections would so consider it. It did not present the history or phases of erythema multiforme, or urticaria bullosa—where, then, shall it be classed? Evidently there is room for a proper and sufficient designation for these cases, the like of which are occasionally met with and have been reported from time to time under many different names.

For a number of years attention has been called, by many observers, to the varieties of appearance presented by certain vesicular and bullous eruptions, and the names which have been applied to them in literature are so many that their simple recital would occupy much time, and the record of them would probably be of no profit. And yet we are to-day far from having a clear and definite understanding and agreement as to the nature, course, and pathology of this class of affections. The majority of text-books mention but three names of principal diseases where serum occurs in vesicles or blebs, namely, eczema, herpes, and pemphigus; others add hydroa and pompholyx, together with erythema multiforme and vesicating urticaria, while some authors record single names, not accepted by other observers. The many varieties of herpes which have been described, and the long discussions in regard to pemphigus, serve to illustrate the difficulty of the subject and the uncertainty still present.

Within the last two or three years, Dr. Duhring has repeatedly called the attention of the profession to the existence of what he believes to be a distinct disease of the skin which had not been before fully described, and which, as will be seen, is made to include such cases as that detailed, and also a number of other eruptions which have hitherto been reported under very different titles; this disease he describes under the name of “dermatitis herpetiformis.” If it can be clearly established that such an affection really exists, embracing the variety of lesions which he has attributed to it, a step in advance will be gained, and a name be given to quite a class of cases which have hitherto been considered anomalous, or have received various designations by different writers. As yet, however, it can hardly be claimed that other workers in dermatology have accepted this disease as an entity, or have largely identified it in practice, certainly not by this name. Every claim of this kind should therefore be criticised by other observers in the same line of study and practice, and be substantiated or refuted, as the case may be.

In order for us to intelligently discuss the subject this evening, I shall, as briefly as possible, condense the description of the main features

of the disease as given by Dr. Duhring,¹ and in doing this I shall, as far as possible, adhere to the language of the author.

According to Dr. Duhring, dermatitis herpetiformis is a well-defined disease, characterized by a variety of symptoms, which, although they appear dissimilar, and perhaps in no way related at first sight, will sooner or later be found to be but different expressions of one process. It is one of the rarer cutaneous manifestations, only one variety of which has been heretofore carefully described, namely, the pustular, by Hebra, under the name of impetigo herpetiformis. In severe cases the disease is ushered in with malaise, shivering, etc. Itching or burning is early pronounced, followed in the course of from twelve to forty-eight hours by more or less eruption, consisting of erythematous, maculo-papular, papular, tubercular, vesico-papular, vesicular, vesico-bullous, bullous, or pustular lesions, as a rule all having peculiarities which distinguish them from the manifestations characterizing other well-known diseases.

The erythematous lesions resemble erythema multiforme and urticaria, being most like the former, but less raised. The vesico-papules are similar to those of erythema multiforme or in the early stages of herpes iris, and where numerous and close together, and occurring upon thickened, pigmented skin, may resemble the first stages of confluent variola.

The vesicular lesions may vary in size from a pin-head to a pea; are flat or slightly raised, broad, angular, or irregular in outline; of a pale yellow, tensely distended, glistening, and without areolæ, unless closely grouped. The blebs vary in size from a pea to a pigeon's egg, or even a hen's egg, raised as in pemphigus, and may have opalescent, cloudy, hemorrhagic, or even pustular contents.

The pustules begin as small, flat, pin-head sized, whitish lesions which grow, as a rule, in from two to six days to the size of a small pea, when they are surrounded by a deep-red, "angry looking," more or less raised areola. Sometimes two or three small pustules appear as a little cluster, as they run together, forming a large pustule. About the time the lesion is at its height, one, two, four, or more new, small, flat pustular points or distinct papules begin to appear in the form of a ring, or as a segment of a circle, immediately around the original lesion, which by this time is somewhat crusted. As these increase in size they are absorbed into the first pustules, the whole being covered with a yellowish, greenish, or brownish, flat, adherent crust. New small pustules may also continue to form around this lesion, as before, or the process may be arrested. The number of pustules varies from half a dozen, scattered, even to hundreds, some about the size of a pin-head or of a pea, others as large as a quarter

¹ Journal of the American Medical Association, August 30, 1884, and American Jour. Med. Sci., October, 1884.

dollar. When they are in close proximity and have run together, large patches may form.

In further description of the disease, Dr. Duhring states that multiformity is the striking feature presented, where cases remain under observation for a number of years. An attack beginning as an erythema may pass rapidly into the vesicular or bullous variety, to be succeeded in a few weeks by the pustular form, and this again by the vesicular or bullous variety, followed perhaps by the pustular for a second time, all these changes or varieties of the disease appearing, it may be, in the course of a month or a year. Also many different lesions may occur at the same time, even pustules and blebs being observed almost contiguous. The eruption may remain of one type, as vesicular, for some time, and then change character, assuming some of the other forms. The tendency is to be vesicular and bullous, the erythematous and pustular manifestations being rarer.

The general character of the eruption is regarded as herpetic because the lesions incline to group, or to appear in small or large patches and to coalesce, and also because in the erythematous and pustular varieties there is a marked tendency to creep or spread peripherally. But Dr. Duhring also states that, in the vesicular and bullous varieties, there is less tendency to group, and the vesicles and blebs may be disseminated at one time, and grouped at another. The irregular, angular, or stellate outlines of vesicles and blebs is also regarded as strongly suggestive of herpes.

The disease usually runs a chronic course, extending over years, even five, ten, or fifteen, the patient suffering more or less continuously, sometimes with periods of months of comparative or entire freedom from the eruption. The disease attacks both sexes, and usually in early or middle adult life. It occurs in single, as well as in married women, though more frequently attacking the latter, especially during pregnancy and in the parturient state. It is without question a neurotic disease, in some cases being manifestly under the control of the nervous system.

In order to put the salient features of the disease in a few words, I will, further, quote the conclusions given by Duhring:

1. The existence is shown of a distinct, clearly defined, rare, serious, herpetic disease of the skin, manifesting itself usually in successive outbreaks, characterized by more or less systemic disturbance, a variety of primary and secondary lesions, and severe itching and burning.

2. The disease is capable of appearing in many forms, having a tendency to run into one another, irregularly; the principal varieties being the erythematous, vesicular, bullous, and pustular, which may occur singly, or together in various combinations.

3. The disease is protean in character, and is remarkable for its multiformity.

4. The pustular variety is the same manifestation as that described by Hebra under the name "impetigo herpetiformis."

5. The term "dermatitis herpetiformis" is sufficiently comprehensive and appropriate to include all varieties of the disease.

6. It may occur in both sexes, and in women independent of pregnancy.

7. It usually pursues a chronic, variable course, lasting years, and is very rebellious to treatment.

In one of his later communications, he claims that many similar forms of eruption, reported with various titles, by different observers, are all merely instances of one process, namely, dermatitis herpetiformis as he has defined it. Thus, he mentions herpes circinatus bullosus, pemphigus pruriginæus, herpes gestationis, pemphigus circinatus, herpes phlyctænodes, pemphigus aigu pruriginæus, certain cases of hydroa, and other eruptions.¹

Such being the description, in brief, given by Dr. Duhring, of what he considers a distinct disease of the skin, capable of demonstration, it remains for us to consider the grounds for this position, and the objections to the same.

The first point which must strike every one is that emphasized by the author, namely, the multiform character of the lesions and the variety of manifestations, which are included as belonging to one disease. But this need by no means be considered a valid objection to its acceptance, for we all recognize at once the very great variety of appearances which may be presented by eczema and scabies, and also those which have been described under erythema multiforme, and also the marvellous variety of cutaneous phenomena excited by syphilis; so that, provided the lesions can be shown to be related to one another, or to depend upon the same cause, or to have the same pathology, their multiformity of appearance need be no valid objection against their constituting a single and well-defined disease. Dr. Duhring states that he has watched some of these cases over a period of years, and that his description is written from a prolonged study of some sixteen or seventeen cases, a number of which he has given in detail² in various publications.

But more serious questions arise in regard to the adoption of "der-

¹ The Medical News, Philadelphia, November 22, 1884, and October 17, 1885.

² Philadelphia Medical Times, July 12, 1884. The Medical News, Philadelphia, July 19, 1884. The New York Medical Journal, July 19, 1884. JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, New York, August, 1884. The New York Medical Journal, November 15, 1884. The Medical News, Philadelphia, March 7, 1885. Amer. Jour. Med. Sci., January, 1885.

matitis herpetiformis" as a distinct disease with the name and description already given, which may be considered under three heads.

1. Have we here to do with a separate disease, possessing uniform characteristics and causes, upon which a sound pathology and treatment can be based?

2. Do we advance any nearer a right understanding of the nature, cause, and cure of these cases, many of which have been classed with other affections, by grouping them together under a single name?

3. Does this name, dermatitis herpetiformis, best express the nature and character of the disease?

In answer to the first question, I would say that the more I see of these cases of multiform, inflammatory eruption, with itching, the more impressed I am that we are as yet unacquainted with their nature and cause, and the more certain I feel that there must be some grave nervous disorder as a prime factor in their etiology; probably some changes will be found in the nervous centres or trunks, as in herpes zoster and pemphigus. Whether the cases all own the same, or even a similar cause, cannot by any means be determined, much more study, both in the direction of clinical record and pathological research, is necessary before their entire history can be written.

I believe, however, that such cases as that I have detailed, and some of those reported by Dr. Duhring and others, belong to a class of disease which has not hitherto been recognized in our text-books, and I quite agree in grouping them together under one designation, and in recognizing them hereafter as representing a particular disease; although I think that later we shall find it desirable to isolate individual instances exhibiting peculiar elements of causation. Whether we are, however, correct in creating a single disease out of the varied pathological changes thus far mentioned, irrespective of their varied causation, appears to be as yet somewhat problematical.

Closely connected with this is our second question, whether we advance any nearer a right understanding of the nature, cause, and cure of these cases by thus grouping them together under a single name. As we have seen, Dr. Duhring claims that quite a number of affections, hitherto regarded as distinct, and described under different names, such as herpes gestationis, pemphigus pruriginosus, hydroa, and the like, are all to be regarded as but phases of this complaint, dermatitis herpetiformis, asserting most positively that the impetigo herpetiformis of Hebra, which was always observed in connection with the parturient state, and was almost invariably fatal, is certainly only the pustular variety of this one great disease, which he never observed to be fatal. Until much more light is thrown on the etiology and pathology of all these affections, it would seem that we lose rather than gain by considering them together,

for the conditions under which they have been observed are so entirely dissimilar. It is difficult from Dr. Duhring's statements to discover just how far he would go in claiming cases which others would recognize as erythema multiforme, urticaria bullosa, herpes iris, hydroa, pemphigus, or even eczema, to be illustrations of the different aspects of dermatitis herpetiformis. It would, of course, be very convenient to have one grand disease into which anomalous and polymorphous eruptions could be thrown, but the very serious question arises whether, by thus contenting ourselves with a name, we are not in danger of neglecting a closer study of the etiology and pathology of these cases, which may lead to more intelligent, and consequently to a more successful treatment.

I think Dr. Duhring has attempted to include too much under his one disease, and thereby weakens its clinical and pathological standing. I am not willing to concede that herpes gestationis, as I have observed and described it, has any connection with the disease under consideration, and certainly cannot agree in placing Hebra's impetigo herpetiformis in this position. Further study would, I am sure, result in showing that the same could be said of other forms of eruption which he seeks to group with the disease under consideration.

Our third question is also an important one: Does this name, dermatitis herpetiformis, best express the nature or character of the disease, if, indeed, there is clinical or other evidence sufficient to warrant the introduction of a new name to indicate certain of these cases which can be grouped together?

The object of nomenclature in disease has long been recognized to be to so name an affection that an intimation is thereby furnished in regard to its clinical phenomena or its pathological elements. Dermatitis is a very indefinite term, expressing only the inflammatory element in the skin, and could be applied to a score of eruptions; if used in the present case it might well be modified by some expletive which indicated more of the character of the disease than the word herpetiformis appears to furnish. From a careful study of all of Dr. Duhring's writings on the subject, and from observation of a number of similar cases, I cannot agree that this name is warranted by the "herpetic" elements occasionally found, whatever may be indicated by that term; a preferable addition would be "multiformis," or even "neuritica," to express the well-recognized nervous element in most, if not all the cases.

The term which I would most prefer would be "dermatitis pruriginosa," as expressing the inflammatory element, and also the single, constant element of itching prominent in all the cases reported.

In conclusion, I may sum up the matter, as it now appears, as follows:

1. Cases occur from time to time in practice where the lesions on the

skin are such, and the disease pursues such a course, that it cannot be located as any one of the well recognized diseases of the skin.

2. It is probable that with advancing observation and knowledge many new diseases of the skin may be isolated and described by the collection of instances of eruption now regarded as anomalous.

3. Some of these peculiar cases exhibit many aspects and phases, and may present a great multiformity of lesions at once or in succession.

4. While we cannot accept the "dermatitis herpetiformis" of Dühring as a distinct disease, including all the forms and varieties of eruption he claims for it, there is undoubtedly sufficient ground for grouping together, under a single designation, some of these cases presenting itching or burning with a multiform, recurring eruption, exhibiting great rebelliousness to treatment.

5. The so-called "herpetic" element in these cases is so slightly marked, and of such an indefinite character, that the term *dermatitis pruriginosa* would seem to express more correctly the clinical or pathological element of the disease than the one chosen.

6. There is a danger lest in accepting a general term to indicate many of these polymorphous, itching eruptions, we lose sight of the peculiar characters and etiological elements in each, and so fail to grasp them from a practical and therapeutical stand point.

4 EAST 37TH STREET.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

161ST REGULAR MEETING, FEBRUARY 23, 1886.

DR. W. T. ALEXANDER, *President, in the Chair.*

DR. BULKLEY opened the discussion of Dr. Taylor's paper on

THE HYDROA BULLEUX OF BAZIN AND DERMATITIS HERPETIFORMIS OF DUHRING,¹ read at the last meeting.

DR. WEISSE said that he had seen three or four cases presenting multiple lesions similar to the cases described by Dühring, some being herpetic, others bullous. He thought that a great deal of time was lost in attempting to give a definite name to skin diseases. He believed that more practical conclusions could be arrived at if we look upon the lesions presenting themselves simply as symptoms, and then striving to ascertain the causes thereof. As to ascribing a neurotic cause to skin lesions, it seemed to him that that was done for want of other data to work on. In late years, he always, in every case of skin disease, had given particular attention to the condition of the alimentary canal, and endeavored to arrest disordered secretions. He was not prepared to say whether the name dermatitis herpetiformis was a proper one.

¹ Page 111, present number.

DR. BRONSON had seen a number of cases which he believed would be regarded by Duhring as instances of dermatitis herpetiformis. He could not avoid the impression that under this term a complication of different affections had been included. He was disposed to admit, however, that it embraced a special affection which was always present, and which was the essential factor in all of the cases. What the precise nature of this special affection was, was as yet undetermined. The name which Duhring had given his disease would imply, perhaps, that it was allied to herpes. But in B.'s opinion the disease was much more nearly related to pemphigus than herpes. From a study of Duhring's and his own cases, he had almost always found that the initial form of efflorescence was a simple vesicle unattended by areola or marked signs of inflammation. Such a vesicle was a mark of pemphigus. It was only subsequent that various inflammatory manifestations were superadded, such as erythema, pustulation, and the like, and these the speaker believed to be simply evidences of common irritation, the result of the itching and scratching which were features of dermatitis herpetiformis. Long-continued irritation of the skin usually led to polymorphous lesions, as seen in pediculosis, for example, or in that of multiform affection which the speaker had termed (having regard to its most prominent manifestation) the urticaria of immigrants. Toxic exanthems were similarly characterized. Hence he was of the opinion that while, for the present, the name and the description of the disease given by Duhring served well enough for purposes of identification, there was in reality included within the term a complex of affections, in which, however, there was invariably present a special morbid factor that belonged to one of the types of vesicular disease, and rather to the type of pemphigus than to that of herpes.

DR. MORROW remarked that he had no well-defined views as to the nature and proper nomenclature of the disease under discussion. If its neurotic origin and nature were clearly made out, he should prefer the term tropho-neurotic dermatitis. He thought the qualifying adjective, "herpetiformis," misleading and objectionable, since it does not appear to form an essential element in all cases. Certainly in three cases under the speaker's observation, which corresponded in their general features with the cases described by Duhring, viz., in the multiformity of the eruptive elements, their chronicity and intensely pruriginous character, the herpetic tendency was not a prominent feature, if, indeed, it could be said to exist.

The speaker thought that Dr. Duhring had been too ambitious in attempting to group together a number of vesicular diseases, the etiological connection of which had been by no means proven, and which may, perhaps, be in no way related, except by the accident of a common eruptive element. He had included in this group the hydroa of Bazin, the arthritic affinities of which had been distinctly asserted by the French school, and also the impetigo herpetiformis of Hebra, which was entirely different in its origin, course, and tendency.

Before a name is given to a new disease, its etiology and nature should be definitely determined.

DR. ALLEN had met with a number of cases that agreed with the description of dermatitis herpetiformis as given by Dr. Duhring, but he did not like the term; he would prefer the name dermatitis multiforme. He had seen the case referred to by Dr. Bulkley, and in that case the herpetic element was absent, and the pustular predominated.

DR. SHERWELL remarked that he had listened with great interest to the reading of Dr. Duhring's original paper. During the recital of Hebra's cases of impetigo herpetiformis, he had been led to wonder if that celebrated professor had ever been much in contact with septicæmic or pyæmic cases, as they, by history and symptoms, correspond very closely to these anomalous eruptions. The marked fatality was also in favor of that conclusion, and in the discussion following the paper at that time, he had made the same criticism, and offered as a substitute, for this form at least, the term dermatitis necrogenica. He thought that the same applied, perhaps, in less degree to herpes gestationis, and believes the conditions due probably to embolism, peripheral in character, or metastatic, in cases of salpingitis or septic matter from broken-down pus deposits in the uterus, or appendages, or surroundings.

He had observed a case, occurring in less than fourteen days after hearing Dr. Duhring's paper, in his service at the Brooklyn Hospital—a boy with diphtheria, in whom a typical eruption of the kind described had appeared late in the dis-

ease, grouped bulke, with pruritus marked over the body and extremities. The child eventually recovered.

He thought, with most of the members present, that dermatology would not be ready to accept the title, it being one that covered too much ground, and that some of the cases described under this heading might be better classed as hydroa and anomalous forms of pemphigus. He did think that if any generic name were insisted on, it should be a negative one, as, for example, dermatitis *multiforme*.

DR. ROBINSON did not believe that it is advisable, in selecting a name for a given disease, to choose one which suggests a certain pathology or etiology as our views of the latter may, and are likely to change, in which case the name becomes misleading. He therefore objects to the term dermatitis herpetiformis as applied by Dr. Duhring, even if it was clear that the lesions described under this name are symptoms of the same condition or state, and prefers one which carries no meaning in itself to the student's mind. Neither does he think that there is an advantage in striving to group under one name lesions, apparently at least, so different from each other in their etiology and pathology; and believes that in dermatology, as in other departments of medicine, the number of names will increase with our increasing knowledge of the subject. He believes that, taking into consideration the forms of the lesion, the course of the disease, and the results of treatment in the different cases, Dr. Duhring has grouped together widely different cases of cutaneous eruptions, some of which are much less closely related to each other than to other already well-known diseases. Many of the mild cases are certainly very closely related to pemphigus, as was shown in his own patient, and which yielded readily to large doses of arsenic at each attack of the disease. The same objection applies to the names suggested by Dr. Bulkley as to dermatitis herpetiformis.

DR. PIFFARD did not believe that the various cases described by Duhring as dermatitis herpetiformis were all examples of the same disease, or that they even belonged to the same group. He was unwilling to put any of them in the class of neurotic affections, until it was shown that they depended on some definite, pre-existing nerve lesion. In zoster or some forms of leprosy, nerve lesions had been demonstrated; not so in the so-called dermatitis herpetiformis and many other affections which some claim to be of nervous origin. He thought that the name employed by Dr. Duhring about as bad a one as he could have selected, inasmuch as pure vesicle formation was by no means a prominent feature of many of the cases; on the other hand, zoster, which is an inflammation with vesicle-formation, is not included. Two years ago he had proposed the term *dermatitis multiforme* as a provisional appellation under which to include these obscure and perhaps unrelated affections, it being far better to use a name that involves no idea of nature or relationship until our knowledge is a little more definite on these points.

DR. TAYLOR said that the discussion had extended far beyond what he expected it would. He thought that Dr. Duhring had grouped too many different varieties of lesion under one name. He agreed with Dr. Robinson that it would be better to give a vague name to a disease when the pathology was not known. The fatal point with Dr. Duhring was that, in describing his cases, he argued on the lines of dermatology and not on those of general medicine. His (Dr. Taylor's) object in reporting the case was to have others carefully studied, so that we might arrive at some definite conclusions.

DR. BULKLEY, in concluding the discussion, said that, if time had permitted, he could have described other cases of so-called dermatitis herpetiformis, and spoke of one in particular occurring in a married woman about 35 years old, in whom crops of eruption, vesicular, bullar, pustular, etc., made their appearance, even when she was under the most careful treatment. At times she would apparently get well, but soon again crops of vesico-pustules would appear without any apparent cause. She had been variously treated, and among other things arsenic in large doses had been given.

DR. PIFFARD exhibited an

ELECTRIC LIGHT FOR SKIN EXAMINATIONS.

The apparatus consisted of a small six-cell portable battery made by the Galvano-Faradic Company, and capable of lighting a four-candle light, and keeping up a steady light for an hour or more.

Reviews.

CUTANEOUS MEMORANDA. By HENRY G. PIFFARD, A.M., M.D. William Wood & Co. Third Edition, 1885, pp. 268.

We are glad to welcome this little book with the imprint "Third Edition," upon its title page. Its merits are so well known that we need not say much more in its praise; and the fact that a new edition has been so soon called for, attests the value that the student and practitioner put upon it.

This edition differs from the former ones, when its title was "Cutaneous and Venereal Memoranda," in that the chapters upon venereal diseases have been omitted. This omission is justified on account of the recent publication in the same series of a most concise and complete manual upon the Venereal Diseases, by Dr. P. A. Morrow. It has further been, to a large extent, rewritten and rearranged, the space given to treatment has been very much increased, and nine woodcuts, illustrative of different diseases, have been added. We would lay special emphasis upon the fact that in this little book we get the result of the author's wide personal experience, and the expression of his independent judgment, not a *resumé* of the ideas of other authors as to etiology and treatment. This makes it peculiarly valuable to the student or to the practitioner who is not versed in dermatology, as it is a great thing to have the guidance of one master when called upon to treat a patient, and not to be compelled to choose between a great number of plans of treatment by many men. It is with pleasure that we commend the book, and express the wish that soon a fourth edition will be called for.

DISEASES OF THE URINARY AND MALE SEXUAL ORGANS. By WILLIAM J. BELFIELD, M.D. New York: Wm. Wood & Co., 1884.

DR. BELFIELD is favorably known as the author of the Cartwright Lectures for 1883 on the "Relation of Micro-Organisms to Disease." Those who are acquainted with the minute and painstaking investigations which were the basis of those admirable lectures will expect to find much valuable information in any subsequent work of the author. In his preface Dr. Belfield says that "it was the author's hope to present a *resumé* of current knowledge of the topics herein discussed, with comments suggested by personal observation and experience," but that, owing to various reasons, he is unable to present a thorough treatise, but prefers to submit the original draft of the book. This is unfortunate, since there is evidence in what is presented that, had the author carried out his original design, he could have produced a very useful book. As it is, the treatise is fragmentary and unsystematic. We think that, while Dr. Belfield, in the main, is right in saying that a lack of care and thoroughness in the investigations of patients is responsible for many failures in the management of urinary and genital disorders, such lack of care in diagnosis is not as widespread as by implication he would have us think. While in America we may not indulge in the cumbersome and oftentimes over-elaborated methods of investigation employed by the German school in which Dr. Belfield was educated, in general in our treatises on these subjects all necessary information is given in a simple and practical manner.

Dr. Belfield's work is divided into two parts; the one treating of the urinary organs, and the other on diseases of the male sexual organs. In the first chapter of Part first, upon anatomical and physiological considerations, we find a fair résumé of our knowledge of the anatomy and physiology of the kidney and its pelvis, the ureters, the bladder, prostate, and urethra, to which is appended a section on general symptomatology, which might have been made more valuable if more concisely written and so much space had not been taken for cases. In the second chapter, much valuable information upon methods of examination is given in a more compact and satisfactory manner. The third chapter, upon the use of the sound and catheter, contains nothing new. We then come abruptly upon a chapter on urethral fever without previous ones detailing the operations to which this grave accident is often a complication. In the main, this chapter is good. Then follow chapters on the precautions to be observed before catheterism, digital examination of the bladder, endoscopy, and on the determination of the urethral calibre which, though good, would have been more valuable if more systematic and tersely written. Then follow chapters on the physiology and pathology of the urine, albuminuria, glycosuria, pigments, the daily amount of urine, urinary sediments, and the clinical examination of the urine, which seem out of place in such a treatise, and which are not remarkable for any striking excellence. They are good in their way, but would have been more valuable if sharply and concisely written. The chapter on diseases of the kidney is the most systematic in the book, and may be read with profit, while that on diseases of the bladder bears inherent evidence that the author writes of what he has seen in the practice of others rather than in his own.

The second portion of the book, devoted to diseases of the male sexual organs, is embraced in about thirty pages, in which prostatic disorders, functional disorders, seminal incontinence, impotence, and sterility are discussed in a discursive manner, and lack that clear conciseness of statement which is especially necessary in handling these subjects. Though we have thus spoken of the shortcomings of the book, which in the main the author admits, we must add that it contains much valuable information, and may yet form the basis upon which, with further extended experience, the author may found an exceedingly valuable treatise.

Selections.

ADULTERATION OF CUBEBS.

THE employment of cubebs as a remedy in gonorrhœa is so extensive that any adulteration of the drug is to be deplored.

At a meeting of the Society of Medicine of Nantes, Jan. 8, 1885, Dr. Menier reported that, in continuing his investigations into purity of drugs dispensed in Nantes, he had in a somewhat accidental way discovered that pure cubebs are adulterated with another form of cubebs whose exact nature he has not yet been able to determine positively, but which he believes to be the *Piper Crassipes*.

Entering his laboratory one day, where a student was pulverizing some cubebs, he found the air laden with the odor of laurel and nutmeg; odors entirely different from that of cubebs. He examined the cubebs at haud, and a number of

specimens obtained from druggists, and found in all berries differing from real cubebs, *Piper longum*. The false cubeb berries had a more grayish aspect, their taste differed from the real, and their odor was strong and camphor-like. When treated with a few drops of concentrated sulphuric acid, real cubebs give a carmine color. This test applied to the suspected cubebs gave a yellowish-brown color, and this is the reaction color said to be characteristic of the *Piper Crassipes*.

The results obtained by Dr. Menier were verified by Dr. Marais, who believes that nowhere in France can pure cubebs be found.—*Gazette Médicale de Nantes*, No. 3, 1886.

RARE MALFORMATION OF THE URETHRA.

DR. POISSON related a rare case of malformation of the urethra to the Société Anatomique de Nantes at its December meeting, 1885. The patient was a boy who, at birth, had a perforated and permeable meatus; but it was noticed that in urination a pouch formed beneath the meatus, and was only emptied by pressure. Later, a small abscess formed in the region of this pouch, and upon opening formed a fistula through which the urine flowed, ceasing at the same time to flow from the meatus.

It was attempted to pass a small sound through the meatus, but it penetrated only to the perineo-bulbar region. When introduced through the fistula, the sound could be passed into the bladder. It was thought that there existed in this case a bifurcation of the urethra, one of the branches, the superior, tending to become obliterated, while the inferior remained permeable.

Dr. Malherbe, who had observed the child with Dr. Poisson, thought that there existed in this case what is seen in cases of hypospadias, that is to say, two canals, one communicating with the bladder, the other with the external opening.—*Gaz. Méd. de Nantes*, No. 3, 1886.

THE ABORTIVE TREATMENT OF URETHRITIS.

URETHRITIS has been treated successfully by Dr. Munnich by having his patients drink large quantities of water or milk, emptying the bladder every two hours during the day, and at least once during the night, followed by the injection of a 3% solution of resorcin.

In four or five days after the discharge has diminished, he injects three or four times during the day and once during the night, and then gradually diminishes the frequency of the injections until the discharge ceases, which usually occurs in about two weeks. It is desirable to continue the injections for some time after the cessation of the discharge.

Letzel has cured fifty-six cases by this method, and adds his testimony as to its benefit. He begins with a two-per-cent solution, and later on uses a three-per-cent solution, as he finds the stronger solution too stimulating at first. He calls attention to the fact that the preparation of resorcin is not always the same. Good chemically pure resorcin is white, and when dissolved in distilled water forms a perfectly clear solution; if the solution be colored, it will produce irritation of the mucous membrane of the urethra.—*St. Petersburger Med. Wochenschrift*, No. 44, 1885.

INTERNAL ADMINISTRATION OF CHRYSAROBIN IN ECZEMA AND IMPETIGO OF CHILDREN.

IN the *Annal. de Derm. et de Syph.* for 1884, Dr. Stocquart first advocated his treatment of a great variety of skin diseases by the internal administration of chrysarobin. Dr. S. now states that chrysarobin is not to be used in every form of eczema, and that it is not the universal panacea for skin diseases that his early experiences with it had tempted him to believe. While further observation is necessary before it can be definitely settled in what classes of disease the drug is indicated, he has found it of decided benefit in eczema and impetigo of children, and here publishes notes on eight cases, four of each disease, in which a cure resulted in from two to nineteen days after beginning its use. The dose used was from 0.005 to 0.04 in twenty-four hours. In all cases, it caused a fading of the redness and a lessening of the secretion; therefor, the doctor regards it as acting by causing a contraction of the blood-vessels and a lessening of the blood supply to the part.—*Monatshft. f. prakt. Dermat.*, January, 1886.

IODOFORM IN VENERAL DISEASES.

A REVIEW of the literature of the subject, joined to his own experience with iodoform in venereal diseases, has led Dr. Bockhart to formulate the following aphorisms in regard to it:

Iodoform is not of the least use in the treatment of gonorrhœal inflammation.

Ulcers and erosions of the vaginal portion of the uterus, the result of cervical gonorrhœa, are amenable to iodoform.

Iodoform should be regarded as a specific against the virus of the soft chancre, and is the best, surest, and most rapid means of treating all sorts of soft chancres.

Suppurating inguinal buboes are best and surest treated with iodoform, especially after the method of Petersen.

In syphilis, the internal use of iodoform is far less satisfactory in its results than that of iodide of potassium, and is most useful in syphilitic neuralgia.

Iodoform is of use against the ulcerated gumma of syphilis, alone of all its lesions, and against this it seems to exercise a specific action.—*Monatshft. f. prakt. Dermat.*, January, 1886.

TREATMENT OF ANGIOMA.

DR. R. CAMPANA has found multiple punctures followed by the application of lint and dried perchloride of iron of great service in the treatment of small capillary angiomas. For twenty-four hours after the operation, there is a superficial reaction in the form of an erythema, but by the second or third day the part treated becomes pale. If one operation is not sufficient, it is to be repeated.

In one case of angioma cavernosum upon the face of a child, he effected a cure in one month by the galvano-cautery. In order to prevent hemorrhage in the first operation, he made use of a perforated metal plate, shaped exactly to the angioma. By this, he was able, not only to prevent hemorrhage, but the canterizations were made at regular distances, and a reduction in the size of the tumor was obtained. In the second operation, the plate was not used, and the cautery was more freely employed to destroy the little islands of angiomatous tissue. There was little hemorrhage, the vascularity having been much lessened by the first operation.—*La Salute*, 1885, Nos. ix. and x.

THE LOCAL TREATMENT OF THE CUTANEOUS LESIONS OF SYPHILIS.

OCCCLUSIVE dressing with Vigo's plaster, made according to the rules laid down by its originator, Chassaignac, cuts short the length of treatment, and is curative even when general treatment is omitted.

The therapy of the local accidents of syphilis varies according to the nature of the lesion, and the age and constitution of the individual.

Many cases of iritis have been cured by the simple procedure of occlusion of the lids and the inunction of mercurial ointment over the brow.

Secondary and tertiary lesions are beneficially affected by local dressings, no matter what preparations be employed. We see physicians obtain good results with iodoform (Féréol); others with powdered subcarbonate of iron (Vidal); Labarraque's solution (Fournier); nitrate of silver and acid nitrate of mercury (Mauriac).—N. DUBROMELLE, *Thèse de Paris*, 1885.

THERAPEUTICAL USE OF LANOLIN.

THIS newly-introduced base for ointments, much praised on account of its penetrating power, has been tried by Dr. Lassar in his clinics. He has found that it penetrates the skin in a few moments when rubbed lightly in, the skin feeling somewhat turgid afterwards, but its surface almost entirely dry. After trying it upon four hundred patients, he finds that it has no irritating or other bad effect on the skin; but, on the contrary, even with an inflamed skin it acts advantageously. It was found very useful in eczema, acne, sycosis, pityriasis versicolor, and scabies, as an excipient for the chosen medication, yielding more prompt results than when the same drugs were used with other bases. Where it is desirable to produce flexibility of the skin, it is best to mix it with twenty per cent of vaseline. In superficial inflammations, he uses lanolin alone. As a substitute for his well-known paste, he proposes the following: \mathfrak{R} Ac. salicyl., 2.0; vaselin., lanolin., zinci oxid., amyli, āā 25. M. lenit. ter. f. pasta. He has found it extraordinarily useful in psoriasis, a twenty-five-cent chrysarobin-lanolin ointment causing all the efflorescences of an obstinate case of the disease to disappear in ten inunctions without the least irritation. It is very useful in seborrhœa capitis even without medicamentation, and makes an excellent pomade with carbolic acid or sulphur. For a rough skin, he recommends the following: \mathfrak{R} Ac. carbol., 1.0; ungt. plumb. lanolin., āā 20.0; ol. amygdal., 10.0; ol. lavend., gtt. xxx. M.—*Berl. Klin. Wochenschr.*, Feb. 1, 1886.

Items.

SYPHILITIC BUBO.—Prof. Neumann, of Vienna, says that, as a rule, they need no treatment, as they disappear usually in the course of the disease without suppurating and without special treatment. Sometimes, if the initial lesion is irritated or the patient is subjected to severe bodily strain, as in long marches, the indolent bubo will become inflamed and may suppurate. He therefore advises rest as a prophylactic. If the inflammation is already active, the local application of cold will be useful. If the bubo is of considerable size, compression by means

of a sand bag, a truss, or an ice bag may be used. To reduce indolent bubos, he makes use of the local application of:

R Tinct. iodini.....30

If suppuration has begun, he opens the abscess early, and gives free exit to the pus. If the suppuration is slight, he punctures the abscess, and injects iodoform. In large abscesses, he advises free incision, scraping out all the *débris* of the broken-down gland, and cutting away all the very thin skin of the cover. The subsequent treatment consists in the use of iodoform. After the exit of the pus from a small abscess, he introduces a plug of iodoform gauze or of gelatin with one and one-half grains iodoform, each plug to be five centimetres long and five millimetres thick. He succeeds in healing the abscesses in eight days by this method. In large abscesses, he packs the whole cavity with iodoform gauze.—*Allgemeine Wien. Med. Zeitung*, December 1, 1885.

SYPHILIS OF THE BRAIN.—In this dangerous manifestation of syphilis, from whatever pathological condition arising, Dr. Gerhardt places his reliance upon mercurial ointment and iodide of potassium for treatment. If the treatment is begun early enough, many of the cases are curable; but if treatment is delayed, there is no hope. Treatment must then be begun early, and be energetic and long continued. He uses daily inunctions of ungt. hydrarg. in doses of three to seven grams, and administers at the same time from two to five grams of iodide of potassium. The more the patient moves about in the open air, the greater, proportionally, must be the amount of the ointment rubbed in.—*Berliner Klin. Wochenschrift*, January 4.

TREATMENT OF SYPHILIS BY SUBCUTANEOUS INJECTIONS OF OXIDE OF MERCURY.—Dr. Watrazewski, of Warsaw, makes in this article another contribution to the literature of the hypodermic treatment of syphilis. He became dissatisfied with the hypodermic injection of calomel on account of the disagreeable general and local reaction to which it sometimes gave rise. After trying various other forms, he now uses exclusively either the black oxydulat (mercurous oxide), or the red oxide of mercury suspended in water and gum arabic, in the dose of 0.06 to 0.10 grams. This is repeated every six to eight days, and requires only three to five injections to cause a disappearance of the eruption. It causes little or no pain, and does not produce abscesses. The mercurous oxide seems milder than the red oxide.—*Centralblatt f. die Med. Wissenschaft.*, January 9, 1886.

ACTION OF MERCURY ON THE BLOOD.—According to the experience of Gaillard, the action of mercury on the blood of syphilitics consists primarily in a diminution of the number of globules and in the amount of hæmoglobin. Very rapidly, however, the normal standard for each is again reached, and even exceeded.

Mercury has surely, therefore, in syphilitics a hæmatopoetic and reconstructive action.—*L'Union Médicale*, September 29, 1885.

SYPHILIS FROM TATTOOING.—Dr. Trotter reports a case in the *Philadelphia Medical Times*, November 14, 1885, of a man who acquired the primary lesion of syphilis while being tattooed by a man who *wet the needle-holder in his mouth* to outline the design. Several weeks after the operation, an ulcer appeared on the figure last executed, and lasted for some time. Three months later a pustulo-squamous syphiloderm appeared on the back, and patches of the same broke out on other regions of the body.

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No. 5.

Original Communications.

A REMARKABLE NEOPLASM OF THE SKIN.

BY

JAMES H. DUNN, M.D.,

Professor of Genito-Urinary Surgery, Syphilography, and Dermatology in the Hospital College, Minneapolis, Minn.

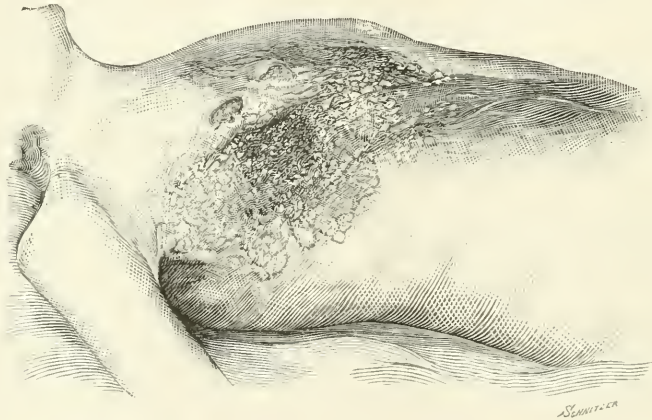
DR. T., an American physician, aged 49, a small delicate man of nervous temperament, had for many years been ailing from obscure subjective symptoms, of which little definite is now known. For some two years past he had been supposed to suffer from pulmonary phthisis. He had moved about, and consulted many colleagues in different parts of the Union. He had suffered from extensive right pleurisy, and the right side sank in, and resulting lateral curvature of the spine occurred about one year ago. Father died of yellow fever; mother suffered from asthma, and said to have died of pulmonary apoplexy; sister died of phthisis. He was an excessive smoker. Had lived mostly in Florida and the South.

About three months ago he came to Minneapolis, under the care of Dr. F. A. Dunsmore, of this city, at whose request I was called to see him.

Dr. D. found the physical signs of absence of the right lung, increased resonance and bronchial breathing on the left; great exhaustion and nervousness; patient confined to bed; no notable elevation of temperature at this or any subsequent time.

The Skin Lesion.—The region of the right breast, extending from the second rib above to the border of the seventh rib below, from the posterior border of the axilla externally to past the mesial line, the skin and subcutaneous cellular tissue was occupied by a peculiar, irregular, nodular new growth, presenting a moderately firm hard feeling to the touch, the nodules varying in size from a small split pea to a hazelnut. No trace of ulceration at any point. The space included within a radius of about three inches about the nipple, corresponding to the older portion

of the growth, was composed of confluent nodules, so crowded and packed together as to increase the thickness of the skin at many points to nearly the extent of an inch, averaging, perhaps, some six or eight lines, forming a large irregular plaque, with uneven nodular surface. On the outskirts of this were larger or smaller nodular areas, of from four to six lines in thickness, and more or less completely confluent, having apparently appeared in patches from the size of a nickel to a quarter, and consisting of from three to eight nodules, which later, by the development of new nodules and the increasing growth of the primary ones, together with hyperplasia of the intervening skin, formed large irregular, intimately adherent tubercular masses, between which were disseminate nodules of the size of a split pea or larger. Beyond this territory were yet newer tubercles, all disseminate, but showing something of a tendency to a sort of circular grouping. The nodules, large and small, presented a firm,



doughy feel, and were of a color varying from purple to vermilion. The newer ones were covered with a nearly normal cuticle, the older portions of the growth with a thickened verrucous epidermis, from which seemed to ooze very slowly a trace of serum, which dried down to a very thin buff-colored crust. The confluent masses below this crust presented a vermilion color from the increased vascularity of the cutis vera, while the spaces of intervening skin, especially at some points, were of a purplish hue, as if from passive congestion. To the eye, the whole territory appeared to be occupied with an irregular nodular mass, some distance above the nipple thicker and massed together, farther from it more scattered, but with some tendency to grouping and heaping up, yet everywhere infiltrated and occupied by disseminate tubercles. It was nowhere adherent to the deep fascia. There was very slight enlargement of the right axillary glands, one being nearly the size of a filbert, but no other glandular enlargements. None of the nodules were movable beneath the skin, but

all implicating and chiefly located in the derma. No melanotic pigmentation. It had spread from the vicinity of the nipple irregularly in all directions. Patient had complained of slight, uneasy, burning sensations in the involved skin at times, though it was not painful to the touch, and there were some pains of a neuralgic nature in the course of the intercostal nerves of that side, due, perhaps, to the lateral curvature and contraction above referred to, in an exhausted and neurotic subject. The duration of the growth, from the first appearance of a group of nodules in the region of the nipple till death, was seven months, during which time it had steadily grown to the above dimensions, by the appearance of new nodules in the outlying healthy skin, as well as among the primary ones in the areas already involved.

Death from exhaustion, after four months' constant confinement to the bed, with great restlessness and defective assimilation. Toward the end there was mild delirium and occasional hallucinations, very likely from cerebral anemiæ. On waking, he often referred to two negroes perched upon the curtain pole of his window.

The autopsy, made by Dr. C. H. Hunter, pathologist to the Minneapolis Hospital College, gave evidence of an old right pleurisy, evidently a so-called quiet pleurisy with effusion, which had seemingly been overlooked before his arrival here, as patient did not seem to be aware of any such diagnosis. Almost complete obliteration of right lung, traces of pulmonary tissue forming a small stump at what had been its root, and the changes secondary to obstructed pulmonary circulation; viz., hypertrophy of the right heart, dilated aorta, old endocarditis with thickened valves, but not permitting regurgitation; nutmeg liver. Kidneys small but normal, except a slight hydro-nephritis. The left lung was studded with many small solid nodules, of the size of a wheat corn, scattered beneath the pleura, and to a less extent throughout its stroma, and presenting a few pleuritic adhesions, otherwise apparently healthy. The mesentery was shortened and drawn up, and attached by its free border to the left inguinal region. At about its centre was a nodule one and one-fourth inches long by one-half inch in thickness, surrounded by numerous smaller nodules, the evident cause of the shortening. The cut surface of these nodules presented a homogeneous white surface streaked by yellow lines, particularly marked at the centre, indicative of fatty degeneration. The stump of the right lung, of the size of a turkey's egg, when cut through, presented a collection of larger or smaller bronchial tubes and vessels with hyperplased connective tissue, from which a foul pus exuded, the evident source of the more or less scanty purulent expectoration of the patient. The parietal pleura was immensely thickened, and the much contracted cavity nearly filled with bloody serum. No nodules discoverable in the remains of the right lung. Microscopical

examination of the nodules of the left lung and mesentery by Dr. Hunter showed them to be richly cellular structures, cells of various shapes, but of connective-tissue origin, with scanty stroma. Microscopical examination of the skin, by Dr. Hunter and by the writer, showed the seat of the new growth to be the papillary and deeper layers of the corium. The papillæ were everywhere greatly elongated, running up through the rete mucosum by pointed tongue-like prolongations, often branching into two or several slender filaments. Scattered through the fibrous reticulum of the papillæ, and more especially at their base and the upper layers of the pars reticularis, were numerous nucleated cells distinctly of the epithelial type, showing a marked tendency to arrangement into nests separated by bands of connective-tissue. Towards the lower strata of the reticularis there appeared to be a marked increase of fibrous and elastic elements; at points, indeed, this was so far the case that the nodules appeared to be poor in cellular elements. The seat of the cellular growth was chiefly in the papillæ and the layers of the corium immediately beneath. At no point could the proliferation of epithelioid cells be traced down from the epidermis, nor were any of the so-called "pearls" so common in epithelioma discoverable. Though not presenting a typical picture of epithelioma, repeated examinations left no doubt in the minds of Dr. H. and the writer that the growth was carcinomatous.

Diagnosis.—Carcinoma cutis.

Remarks.—So far as my observation and reading goes, the case is most interesting, if not unique.

The location, small size of the nodules, method of eruption, tendency to grouping, slight implication of glands, strict limitation to the derma, small extent of internal deposits, and these, *if malignant* (this not demonstrated), in organs only connected through the circulation of the blood, together with the location over a lung cavity, long the seat of irritation and continued pathological processes, render the neoplasm not only extraordinarily interesting, but raises many queries and speculations which, since they are probably unanswerable in the present state of our knowledge, it were folly to record.

It seems hardly probable that the skin lesion was secondary to the visceral nodules, though those in the mesentery may have been, and probably were older than the cutaneous growth. Before repeated microscopical examinations were made, and rendered the diagnosis untenable, the growth was thought to be sarcomatous, though its course, history, and appearance would, farther than the lack of ulceration, lend but slight encouragement to the opinion. By exclusion, epithelioma was rejected, largely on account of the long duration and great extent of growth without ulceration, as well as the very multiple method of appearance.

NOTES ON A CASE OF LICHEN SCROFULOSUS.

BY

WM. S. GOTTHEIL, M.D.

LICHEN scrofulosus s. L. scrofulosorum is an affection of fairly rare occurrence. Neumann¹ rates its frequency at 0.3 per 100 cases of skin disease in adults, and at 0.5 per 100 cases in children. L. D. Bulkley,² in an analysis of 8,000 cases occurring in a public and private dermatological practice, records but a single case. Probably its frequency in this country is not greater than 1 in 5,000 cases of skin disease.

The literature of the disease in English is quite scanty. Two cases have been reported here, one by E. B. Bronson,³ and one by F. S. Shepherd.⁴ In England, Tilbury Fox⁵ has described a series of six cases, and H. Radcliffe Crocker⁶ has reported one. On the continent, the affection seems to be of somewhat commoner occurrence, especially in Vienna, where the elder Hebra first differentiated and described it. Lailler⁷ and Hardy⁸ describe cases of the malady, but do not mention its frequency.

All the recorded cases show a very marked agreement in their clinical features. All occurred in young persons, and most of them in children; the youngest case being seven years old, and the oldest twenty-two. In spite of Kaposi's⁹ dictum that the disease is confined almost entirely to men, six out of the nine recorded cases occurred in females. In all instances save one, the eruption presented the characteristic appearance of larger or smaller, sharply-defined groups of isolated, brownish-red and slightly scaly, pin-head sized papules, scattered in greater or less abundance over the body. In the one exceptional case of Tilbury Fox, the lesions were not grouped, but were disseminated irregularly over the entire surface. Subjective manifestations were practically absent. Finally, in every case there was present more or less markedly some

¹ Neumann, "Hautkrankheiten," Art. L. Scrofulosorum.

² L. D. Bulkley, "Analysis of 8,000 cases of skin disease," Archiv of Dermat., Oct., 1882.

³ Bronson, "Case of Lichen Scrofulosus," Arch. of Dermat., i., p. 138.

⁴ F. S. Shepherd, Canada Med. and Surg. Journal, 1880-1, v. ix., p. 280.

⁵ Tilbury Fox, "Trans. Lond. Clin. Soc.," v. xii., p. 190, 1879.

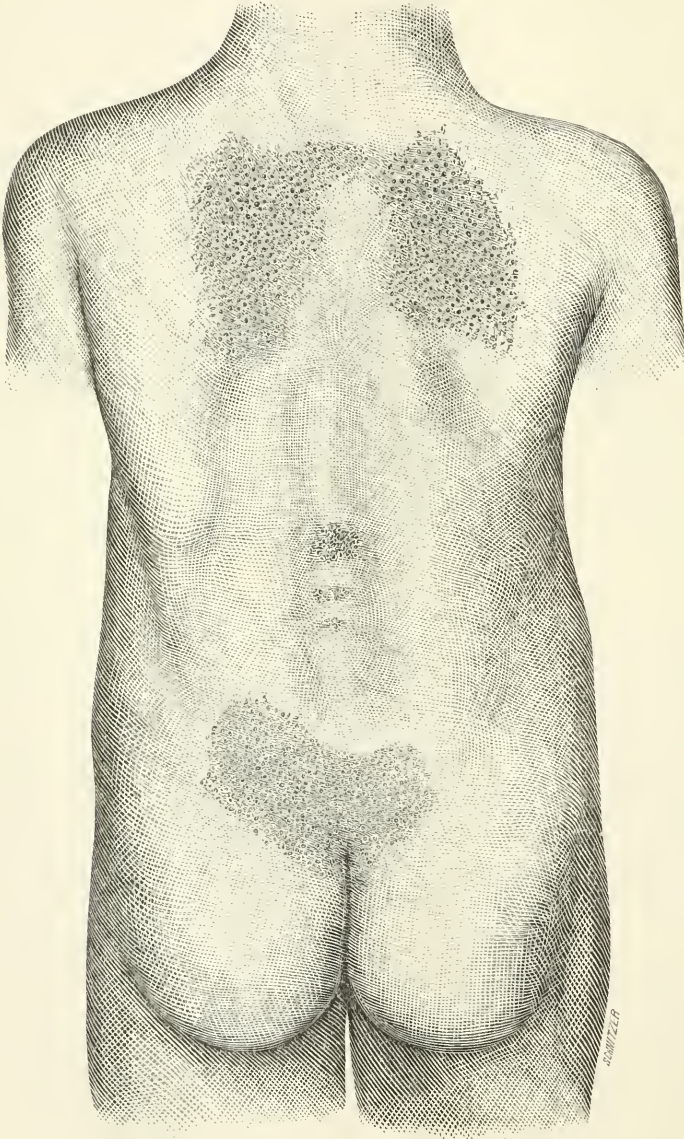
⁶ H. Radcliffe Crocker, "Trans. Lond. Clin. Soc.," v. xii., p. 195, 1879.

⁷ Lailler, La France Méd., 1877, pp. 513, 530.

⁸ Hardy, Gaz. des Hôp., 1877, pp. 1161 and seq.

⁹ Hebra u. Kaposi, "Lehrbuch der Hautkrankheiten," Art. L. Scrofulosorum.

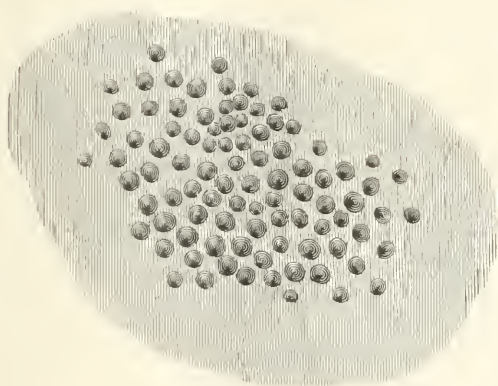
manifestation of those chronic inflammations with a tendency to early caseation which we call "scrofula," or there was true tubercular disease.



Three cases suffered from chronic bone disease; three had had hæmoptysis and other lung symptoms; two had chronically inflamed sub-

maxillary glands; one had lupus erythematosus of the face; and in four cases, there was a well-marked phthisical family history.

The patient, Eddie Bradley, of whose case the accompanying drawing is a fairly accurate representation, was first seen on July 22, 1885. There were then upon his body ten groups of the eruption, exactly similar to one another, and uniformly composed of aggregations of round, pin-head sized, brownish-red, flattened, slightly scaling papules, the skin between the elevations being perfectly normal, and the individual lesions showing no tendency to coalesce. No acne papules or scratch-marks were present. On the abdomen, midway between the umbilicus and the pubes was a narrow semicircular patch some seven inches long, with its concavity turned upwards, and above this on either side, in the mammary line, another smaller one. Posteriorly, two large patches, some six inches in diameter, occupied each the region of one shoulder-blade, being joined by



a connecting band of eruption at their upper border; whilst just above the beginning of the natal fold was another and more irregular group. Four smaller patches occupied the hollow of the back. The extremities were free, as they almost invariably are, with the exception of two well-marked quarter-dollar-sized patches situated in the skin one at either side of the right ligamentum patellæ.

The patient is a boy nine years of age, and is in perfect health. It is worth noticing that no trace of strumous or scrofulous taint is to be found about him, and that the family history is exceptionally free from phthisis. The patches had certainly existed for two years, if not for a longer time, and had caused no further annoyance than a slight occasional itchiness. They were noticed first upon the abdomen, and had slowly grown to their present extent. According to the mother's statement, the area of affected skin was increasing in size at the present time; but no disappearance of any patch once formed had been noticed. The boy was kept under ob-

servation for some months without treatment; but not the slightest change was noticed in any of the old papules, nor did any new ones appear. Under the free use of cod-liver oil internally and externally, the papules are gradually flattening out and the patches are fading away.

7 W. 50TH STREET.

THE BULLOUS FORM OF IODIC ERUPTION.

BY

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Clinical Professor of Venereal Diseases, University of the City of New York, Surgeon to Charity Hospital.

(Concluded from page 100.)

AS before intimated, the literature of this eruptive form is comparatively limited. As early as 1842, Ricord¹ refers to a rupia-like eruption, presenting the characters of a cachectic rupia, which he had observed upon the forearms and legs of a patient who was taking iodide of potassium. The eruption disappeared upon discontinuing the drug, and reappeared when its use was resumed. While this eruption was probably closely allied, if not identical, with that under consideration, its clinical characters were not traced with sufficient precision to justify its inclusion under this category. The first authentic case of bullous eruption caused by iodide of potassium was reported by Dr. John O'Reilly in the *New York Medical Gazette*, January, 1854. In a paper read before the American Dermatological Association, in 1879, Dr. J. Nevins Hyde² gives a very interesting resumé of our knowledge of the bullous eruption induced by the ingestion of iodide of potassium. In connection with a case which came under his observation, he gives a tabulated statement of the clinical features and other points of interest in fifteen cases which he had found recorded up to that time.

He includes in his statistics five cases of Hutchinson, three of which, it must be remarked, are of somewhat doubtful authenticity, as the pathogenetic action of the iodide was not suspected when the cases were under observation, and in one case it was not definitely known that the patient had taken the drug. But as the nature and origin of the eruptions were at the time obscure, and, moreover, they bore such a striking resemblance to a bullous eruption caused by iodide of potassium in two patients subsequently observed by Hutchinson, he classed them all as "hydroa from iodide of potassium."

¹ Ricord, *Bulletin Gén. de Thérapeutique*, t. xxiii., 1842, p. 162.

² Hyde, *Archives of Dermatology*, October, 1879, p. 333.

Since the appearance of Dr. Hyde's paper, I have found reports of a number of other cases: O'Reilly's case, which had been overlooked by Dr. Hyde; one case reported by Thin;¹ two cases reported by Hallopeau;² one case by Besnier;³ one case by Pellizzari;⁴ one case by Lindsay;⁵ one case presented by myself⁶ before the New York Dermatological Society, and a second case, which forms the subject of this paper.

From a careful study of these cases, the general characteristics of the bullous form of iodic eruption may be thus described:

The Quantity of the Drug Required to Develop the Eruption.—In a majority of cases, the quantity of the drug ingested seems to have been immaterial, its irritative effect upon the skin being determined rather by the idiosyncrasy or susceptibility of the individual. In some cases, small doses—smaller indeed than are required to produce the ordinary physiological effects of the drug—sufficed to bring out the eruption. In one case, a single dose of 5 grains; in another, two doses of $7\frac{1}{2}$ grains; in another, three doses of 15 grains; in three cases, 1 drachm; in one case, 4 drachms; and in one of my cases, 900 grains. It will be remembered that in this case the cutaneous phenomena began to appear after 300 grains were taken, and were intensified in severity and extent by the continued use of the drug after symptoms of intolerance had declared themselves. In some of the cases, the eruption was developed a number of times, either because the toxic action of the drug was not recognized, or because the observer wished to test the susceptibility of the patient, and it is worthy of note that, while it may have required large and continued doses to produce the eruption in the first place, much smaller doses sufficed to promptly redevelop a succeeding outbreak. In Besnier's case, the eruption was first developed by 2 grams, the second time by 1 gram, and the third time by 10 centigrams.

The rapidity with which the eruption develops.—The length of time which intervenes between the administration of the drug and the first appearance of the eruption varies according to the predisposition of the individual and the size of the dose; usually it is from the third to the sixth day. Exceptionally, this period may be reduced to a few hours or lengthened to several weeks. In one case (Duhring's, referred to by Hyde) it was only four hours; in two cases, twelve and twenty-four hours; in one case, three weeks; in another, two months; in the greater number, from three to six days. In Besnier's case, a single dose of the iodide

¹ Thin, "Medico-Chirurgical Transactions," 1879, p. 189.

² Hallopeau, *L'Union médicale*, No. 41, 1882, p. 481.

³ Besnier, *Annales de Dermatol. et Syphilig.*, March, 1882, p. 168.

⁴ Pellizzari, *Archives of Dermatology*, July, 1881, p. 267.

⁵ Lindsay, *British Medical Journal*, March 19th, 1884, p. 602.

⁶ Morrow, *JOURNAL OF CUTANEOUS AND VENEREAL DISEASES*, Dec., 1884.

taken at night was followed the next morning by itching and the development of bullæ and pemphigoid phlyctenulæ. This experience was repeated three times in succession.

The locality of the eruption.—The bullous eruption has for its seat of predilection the face, neck, and dorsal surface of hands and wrist; sometimes it is seen upon the lower extremities, more rarely upon the trunk. In two instances it occurred upon the palms, and twice on the mucous membrane of the mouth. It has been observed but once upon the hairy scalp. In the case reported by O'Reilly, the bullæ were situated upon the forehead, lips, under left clavicle, inner side of right thigh and side of prepuce. In one of Hallopeau's cases, the face and hairy scalp were the seat of the eruption; in the other, the parts of the cranium devoid of hair, the forehead, eyelids, and backs of hands. In Thin's case, the face and dorsum of the hands; in Besnier's case, the head, neck, chest, and arms; in Pellizzari's case, the arms and legs; in Lindsay's case, the face, trunk, and upper extremities; in both of my cases, the face, neck, and dorsal surfaces of forearms, wrists, and hands were the localities affected.

Clinical features.—The special features which characterize this eruption are the development of bullæ of varying size, often commingled with vesicles and small pustules. The lesions usually make their appearance as vesicles or vesico-pustules which rapidly increase in size; they may remain discrete, or coalesce with neighboring bullæ. In other cases they begin as hard papules, the shot-like character of the papules suggesting the commencing stage of variola. This resemblance is heightened by the rapid transformation of the papules into vesicles, and their tendency to umbilication, which is quite manifest in some cases. There is generally more or less thickening or infiltration of the skin, and the lesions may be surrounded by an inflammatory areola, variously described as "erythematous," "bright red," or "a dark wine color." In some cases the epidermis is uplifted without inflammatory swelling of the skin, presenting the appearance of a blister produced by a burn. In Hallopeau's cases the bulla was the initial lesion, the erythema developed secondarily. In Lindsay's case the eruption was described as "an eruption of blisters, compared to 'potato apples,' each blister surrounded by a series of bright-red concentric rings."

The size of the bullæ.—The lesions are variously described as the size of a "pea," a "lentil," a "cherry," "pigeon's egg," "one and a half inches in diameter," "very large," etc. It is obvious that their volume will depend somewhat upon whether they remain discrete or become confluent, in which case they may attain enormous dimensions. The exaggerated development of all the eruptive features in my second case was doubtless due to the continued use of the drug after its toxic action had begun to be manifest.

Contour.—The lesions are regularly-rounded or semi-globular when discrete; irregular or sinuous when formed by the fusion of neighboring bullæ. Exceptionally the lesions may present a distinctly umbilicated appearance.

Color.—At first “pale,” “yellowish-white,” “waxy yellow;” later, “reddish,” “purplish,” “dark purple,” “color of intestine,” “dirty-blue,” etc.

Consistence.—The lesions are tensely distended, and more or less firm, in two cases suggestive of tumors filled with solid contents.

Contents of lesions.—At first clear serum, which later becomes turbid, assuming a latescent or grayish-opaque color, sero-purulent or sanguinolent. If the bullæ do not rupture readily, the contained fluid may degenerate into a thin, bloody pus, extremely offensive. In one case microscopical examination of liquid showed presence of red globules and large number of white globules, certain of these elements in process of degeneration, also considerable number of vibriones. The exudation of red blood-corpuscles sometimes, though rarely, occurs in the initial stage of the bulla. Contents of bulla have been repeatedly examined for traces of iodine, but always with negative results.

Duration of eruption.—The bullous form is no exception to the general law of drug eruptions, “*sublata causa, tollitur effectus.*” In any case, no matter how marked the cachexia, or how grave the organic complications, the eruption begins to improve soon after the withdrawal of the offending cause. Its more or less rapid involution depends, of course, upon the severity and extent of the lesions and the recuperative powers of the individual. The walls of the bullæ rupture and discharge their contents, which dry up, forming thin crusts; upon falling they leave pigmented spots. In some cases there is a slight ulceration of the floor of the bullæ, involving the upper layer of the corium, which leaves superficial scars. Some authors speak of successive ulcers following the bullæ. In O'Reilly's case there was sloughing of the parts upon which the bullæ were situated; the penis was sphacelated, and entirely thrown off up to the pubes.

Co-existence of renal and cardiac complications.—In five of the nine cases which I have collated, cardiac complications were noted as being present, in three of the cases associated with albuminuria. They may have existed in other cases without having been detected. As previously pointed out, we can readily understand why defective elimination of the drug should act as a co-factor in the causation of cutaneous irritation. The greater part of the iodine is normally eliminated by the kidneys within twenty-four hours after its ingestion; when this channel of egress is blocked up, the drug is longer retained in the vascular channels, and exerts its irritant action upon the tissues. But why cardiac

disorders should produce a morbid determination of the drug's action towards the cutaneous system is not so evident. Thin has suggested that this may be due to the feeble heart impulse and consequent sluggish circulation in the cutaneous capillaries, allowing the iodine or its compounds present in the blood time to attack and injure parts of the vascular wall. It is needless to say that the retarded elimination of the drug does not explain the occasional occurrence of the eruption within a few hours after the ingestion of a single insignificant dose.

Fatality.—Death occurred in four of the nine cases. As is well known, the disturbance of the general health from a drug eruption is, in the great majority of cases, slight and of transient duration, and its influence upon mortality practically *nil*. The fatal termination in these cases was doubtless due to the existence of grave organic lesions, although in all of them a considerable quantity of the drug had been administered. Thin's patient, who had "renal and mitral regurgitant disease," died nine days after the appearance of the eruption. In Hallopeau's patient, who had "aortic contraction with valvular insufficiency and slight albuminuria," death occurred on the twentieth day after the eruption began to appear. Pellizzari's patient, in whom the eruption was repeatedly developed, died several months later from "heart disease," and my own patient, who had "mitral insufficiency and atheromatous deposits, with albuminuria," died six weeks after the eruption first appeared.

Histological appearances.—In two of the cases a microscopical examination of the lesions was made. Hallopeau found that the bulla was situated in the median part of the mucous body, which was in part destroyed, papillæ of the derma not involved. The walls of the bulla were composed of the horny layer considerably hypertrophied, the stratum granulosum, and a part more or less considerable of the rete mucosum, which remains adherent to the stratum. Thin found the roof-wall to be composed of a ragged, and partly disintegrated epidermis. The appearances indicated that the formation of the bulla was the result of an injury to the walls of the blood-vessels of a limited area, attended with effusion of the constituent parts of the blood, the pressure of which displaced the bundles of connective tissue, ruptured the mucous layer of the epidermis, and accumulated under the horny layer of the epidermis, as is the case with all similar effusions. The size of the bulla and the nature of its contents depend in such cases upon the degree and extent to which the vascular wall is damaged, and on the size of the affected vessels.

Certain additional points of interest in connection with the bulbous form of iodic eruption may be alluded to. As a rule, the vesicular element is alone present; exceptionally it may be accompanied with other eruptive elements, constituting a polymorphous eruption. In Pellizzari's case, three eruptive forms of an entirely different character were

present at the same time. On the left forearm near the wrist there were three slightly elevated papules the size of a cent, with a rough surface and of a dark strawberry color. Upon the arms and legs were eight or ten lesions about one-half inch in diameter, similar to the bullæ of rupia, with a rather deep base, surrounded by a circumscribed dark-red areola; on the top, a bulla like that produced by a burn. The third form was represented by three tumors, from the size of a nut to that of an apple, deeply seated in the subcutaneous tissues. In the case presented by me before the New York Dermatological Society, there was present a variety of eruptive elements, papules, tubercles, furuncles, vesicles, pustules, and bullæ.

In a majority of cases, the eruption is preceded by subjective sensations of burning and itching; it may or may not be accompanied by the ordinary physiological effects of the drug. In aggravated cases, there may be cephalalgia, iodic fever, with considerable elevation of temperature, and the group of symptoms peculiar to constitutional iodism, such as profound depression, insomnia, tremors, etc.—the result of the toxic action of the drug upon the nervous system.

One or two conclusions of practical interest may be drawn from this clinical study. 1st. This form of iodic eruption may be confounded with variola and syphilis. As Hutchinson has pointed out, the shot-like character of the papules which precede the development of the bullæ resemble those of the early stage of variola. The localization of the eruption and the tendency to umbilication are additional elements of confusion. The free exudation from the broken bulla, with the admixture of blood, may form crusts not unlike those of syphilitic rupia. Hyde has suggested that the “rare vesicular and bullous lesions, recorded as occurring in acquired syphilis, may have been induced by the administration of iodide of potassium for the relief of the disease.” 2d. The proneness of this eruptive form to develop in connection with cardiac and renal disorders, suggests the necessity of observing a certain amount of caution in administering iodide of potassium to patients in whom these complications are known to exist.

The following conclusions in regard to this eruption may be formulated:

1. The bullous form of iodic eruption is comparatively infrequent.
2. It has for its seat of predilection the face, neck, forearms and hands, exceptionally it may occur upon trunk and lower extremities.
3. There seems to be no definite relation between the amount of the drug ingested and the production of the eruptive accidents; they may follow, indifferently, a single insignificant dose, or may appear only after the long-continued use of large doses.
4. In the former case, the incidental effects of the drug upon the skin

depend upon idiosyncrasy, in the latter class of cases the pathogenesis is more obscure.

5. The proneness of this eruption to develop in connection with cardiac and renal disorders would seem to indicate that these conditions stand in the relation of a determining cause, rather than a mere coincidence.

6. The practical inference may be drawn that caution should be observed in the administration of iodide of potassium when these complications are found to exist.

CASE OF ERYTHEMA VENENATUM.

BY

FREDERICK W. PUTNAM, M.D.,

Binghamton, N. Y.

MY reasons for presenting a report of this case are the peculiar clinical history attending it, and the possibility of error in diagnosis.

Dec. 7, 1885, Mrs. F., Irish, of this city, called at my office and said her five-year-old boy had a sore throat, but that he was not very sick, and she wished me to give her something for the throat trouble. I gave her powdered muriate of ammonia, a favorite remedy of mine in such conditions.

The next day I was sent for in great haste. Upon reaching the house, she said that the patient had been vomiting all day, and that he had a red eruption upon his body. He had had only a slight evacuation from his bowels in the past forty-eight hours. He complained of his throat, and had some fever, with a pulse of 120. The tonsils and surrounding structures were simply hyperæmic. I did not note the temperature. His cheeks were not flushed and his skin was not unusually hot. His tongue was covered with a whitish fur, except at the extreme tip, which looked a good deal like the beginning of the "strawberry tongue." Still the papillæ were not unduly raised. Upon his body was a fine, punctate, but pretty generally diffused scarlet eruption.

The boy had never had scarlet fever, and cases of it were occurring here and there about the city. Here was a case of a boy, five years of age, who never had had scarlet fever, who had some sore throat, who had been vomiting more or less for twenty-four hours, whose tongue was covered with a whitish fur, who had some fever, and who had a punctate

and more or less diffused scarlet eruption appearing on the second day of illness. Certainly a very fair clinical history of scarlet fever.

This boy was evidently a comparative stranger to the cleansing influences of soap and warm water, and a fair supply of "mother earth" was adhering to his integument. In arriving at a diagnosis, this admixture of dirt with the eruption had to be eliminated. By selecting a portion of the chest least covered by extraneous matter, I discovered that no line remained after drawing the finger over the surface, even for an instant. I also noticed that the eruption extended only midway up the neck, and did not extend down on the thighs. About the middle of the neck there was a distinct line extending completely around the neck, between the eruption and the healthy skin. Up to this line, the eruption was very prominent; above it, there was no eruption.

The boy had been wearing a new cheap red-flannel undershirt for four days, and I discovered that the top of the shirt and the upper border of the eruption were in the same plane.

I directed the mother to remove the shirt, and the boy made a rapid recovery. I gave him one cathartic dose of hydrarg. submuriate, and small doses of tr. of aconite root every half-hour for the remainder of the day, and directed him to continue the ammonia.

I believe that the throat trouble was simply a coincidence, and that the systemic disturbance was due to the poison contained in the coloring matter of the shirt.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

162D REGULAR MEETING, MARCH 23, 1886.

DR. W. T. ALEXANDER, *President, in the Chair.*

DR. JACKSON presented a case of

GENERAL CHROMOPHYTOSIS.

A German, about 35 years old, who, for the past five years, has had a pretty general eruption of chromophytosis scattered over the trunk and upper extremities. The patient enjoys good health, with the exception of excessive perspiration.

DR. CAMPBELL showed three cases of

MERCURIAL STOMATITIS.

A woman and her two children, who have been salivated for the past five or six weeks. The woman says that she purchased some canton flannel that had been

used to wrap around mirrors, and thus became impregnated with the quicksilver. She states that two or three days after washing the flannel, her mouth became sore and her teeth loosened; her children were similarly affected. When first seen, the patients presented all the appearances of mercurial stomatitis, with the mercurial odor quite prominent. The woman denies having taken any kind of medicine, or having used any local remedies previous to the occurrence of the symptoms of salivation.

DR. TAYLOR exhibited a

PECULIAR CASE OF DISCOLORATION OF THE SKIN IN A PATIENT SUFFERING FROM
CIRRHOSIS OF THE LIVER.

M. T., Irish, laborer, 57 years of age, was, according to his statement, well until eight months ago. He has always worked hard, has been much exposed to severe weather, and during the past twenty years has been addicted to alcoholics. Within the past year, the patient's appetite has been poor; he has lost in weight from fifteen to twenty pounds, and is much reduced in strength. His complexion is of a dark, muddy color. On physical examination, the liver was found much contracted, and the spleen enlarged to twice its normal size. The urine was frequently examined and found to be of high specific gravity, small in quantity, and contained large quantities of urates and blood pigment. About a year ago, his feet began to swell, and he walked with less ease than formerly. Coincidentally with the swelling of the feet and legs, the latter became the seat of pigmentation, which is well shown in the drawing to involve chiefly the middle portion of the legs in an irregular, but generally continuous patch. The remaining portion of the integument of the legs and feet was somewhat darker in color than normal. There was, however, nothing unusual in the pigmentation of the leg more than is often seen in cases of chronic œdema of these parts, and following eczema and varicose veins. The peculiar and unusual discoloration begins over each patella and, running up in a patch on the inside of the thigh, ends just below the lower border of the scrotum. It may be well to state here that, although there is not strictly a varicose condition of the veins, the walls of these vessels can be distinctly felt to be thickened.

Over the patellæ there is a patch of very dark brown discoloration, which is continuous with the patch on the inside of the thigh which there becomes studded with irregular-shaped spots of normal skin, the whole presenting a clearly defined mesh or network, the brown portion of which is rather more extensive than the white. As the patch is followed up the thigh, it becomes narrower until it ends at about the opening in the fascia for the femoral vessels. The appearance of the pigmentation is peculiar and interesting. Beginning at the knee as a deep brownish-black patch, it gradually diminishes in intensity until at the periphery of the patches it is lost. Above this, under the skin, can be seen a faint but perceptible coloration, in a mesh form, which seems to be due to the appearance of the venous radicles through the skin, which is here thin and delicate. The latter condition of the veins can sometimes be seen in persons having a delicate skin after a cold bath or exposure to cold. My explanation of this abnormal chromatogenous development is that it is due to stasis, caused by impediment to the circulation from visceral disease, and that the affected cutis is permeated with pigment of the blood which has escaped from the vessels, and that the mesh-like appearance of the patches is due to the changes which have taken

place in the integument immediately over the large veins of the thighs. In this case, there was no prominence of the veins over the abdomen.



DR. SHERWELL believed it to be a venous stasis, and that the ecchymosed condition showed a low state of health due to excessive indulgence in stimulants.

DR. BRONSON said that he was under the impression that he had observed a similar condition in the region of the knee. An interesting point arises whether the discoloration of the skin is due to a deposit in the corium or not.

DR. ROBINSON had never seen pigmentation above the knee, with so little varicosity. The pigmentation was in his opinion due to an enlargement of the capillaries.

DR. ALLEN had seen pigmentation about the thighs in persons affected with syphilis.

DR. MORROW thought that hæmorrhagic points in this situation, resembling a

purpura, was an interesting feature. A point worth determining was, whether these spots were due to the bandaging or the administration of the digitalis.

DR. TAYLOR considered the case an interesting one also from a medical point of view. In persons with cirrhosis of the liver there is often a large abdomen, with varicose veins; the legs are also attenuated like pipe stems. This man's abdomen is not enlarged and the legs are about normal in size. The ecchymoses on the legs spoken of by Dr. Morrow are due to the pressure of the bandage.

DR. ROBINSON presented a case of

KERATOSIS OF THE NAILS.

The patient, a man, 26 years old, has had thickening of the nails ever since he was eighteen months old. All the nails of the hands are thickened to a greater or lesser extent; some as much as three quarters of an inch. There are also on the sides and the fore edges of the nails papillomatous-like growths. Both heels are thickened and macerated, presenting very deep fissures which cause great pain in walking. There is also considerable hyperidrosis.

DR. BRONSON thought that the case resembled a class of cases described by Unna in which there was a marked hereditary tendency. He had seen many cases resembling this one, but they occurred on the feet of elderly people. He had never seen a case occurring so early in life.

DR. LUTZ, of Germany (by invitation), said that he had seen the cases described by Unna, and in them there was marked thickening of the palms as well. There was marked pigmentation in patches, such as is often seen in cattle. In this case the malformation of the nails is peculiar, in being so regular, in contradistinction to onychogryphosis where the thickening is irregular.

DR. ROBINSON said that he showed the case because of the peculiar regularity in the thickening of the nails, which had already been referred to, and the smoothness of their upper surface. Where there is no friction it appears to be a papillomatous growth, occasioned by hypertrophy of the papillæ. He had never seen a case like it occurring in early life. He proposed applying nitric acid to the growths.

DR. MORROW suggested the use of salicylic acid locally.

DR. SHERWELL presented a case of supposed

LUPUS OF THE LARYNX.

Mabel P., 16 years old. No history of any disease in her immediate family. Four near relatives of her mother have died of what was diagnosed as carcinoma.

About four years since, without any marked antecedent symptoms, a succession of profuse hemorrhages came on, unattended with pain, and apparently from the larynx. About four days after, an eruption appeared, fugitive in character, appearing and disappearing rapidly and confined to lower limbs, which seems from description to have been erythema multiforme; certainly did not resemble a specific eruption. From this time forth she commenced to grow aphonic, and this has persisted up to present time.

In September, 1885, complete aphonia existed. On examination with the laryngoscopic mirror, I found tubercular excrescences or nodular infiltrations on and below vocal cords, notably about both commissures; the same irregular nodes over the site of arytenoid cartilages, and the epiglottis had lost about one-quarter of its size from the free edge backward, from an ulcerative process then present and active, of a slow, erosive, worm-eating kind. Also on the palate just above uvula there was present the same infiltrated and worm-eaten ulcer that is now present, but of greater extent and the borders more pronouncedly thickened than at present.

She was given various remedies, both local and general; among others, anti-syphilitics, but without much effect. Afterwards tonics and hæmatics were given, under which her general health was improved.

Lately I have been using the faradic current externally over crico-thyroid; there seems to be gradually more evidence of movement and an approach to approximation of the thickened cords, or what is left of them.

I have not, however, gotten much benefit from applications to the ulcer on palatal arch: and the ragged left tonsil, from which I at one time ablated a piece about the size of the last phalanx of her little finger, seems to be growing large again from proliferation of tissue of some kind. The conviction has been gradually growing upon me that we have here a lupus of the tissues, a disease we know to be quite rare in this locality.

DR. BRONSON thought that it would be necessary to have more data before making a diagnosis, but his impression was that the lesion progressed more rapidly than a lupus ordinarily did.

DR. LUTZ said that the clinical appearances were those of a lupus or a tuberculosis.

DR. ROBINSON would call it a local tuberculosis.

DR. SHERWELL thought that lupus was the best name to give the lesion, although he still held the diagnosis *sub judice*. The patient at no time has shown any evidences of phthisis pulmonalis. He does not believe it to be a carcinoma because there has been no pain worth mentioning.

DR. ROBINSON then showed a case of

NERVE NÆVUS.

The patient, a child five months' old, has a sharply defined, slightly elevated eruption existing on the shoulder, and extending down on the flexor surface of the arm of the left side. It made its appearance soon after birth, and is of a dark brown color.

DR. LUTZ said that in Germany a lesion would not be called a nævus, unless there was a certain amount of vascularity. This presented features both of keloid and papilloma.

DR. ALLEN afterward presented a case of

VEGETATING SYPHILODERM OF THE FACE.

The patient, Mrs. E. W., colored, about 40 years old, presented herself June 24, 1885, for treatment, having an enormous cauliflower-like appearance of the nose, fissured, ulcerated, covered with *dirty crusts, and foul-smelling*. She stated that it had begun two years before, as a *pimple* in the nostril. Her husband had been healthy, and she had never been sick before; nor did she give any history pointing to syphilis, except that nineteen years ago she had an eruption on her shoulders (probably acne), and had lost two children, one "with lumps in its neck." She has four healthy children living. For a month, she was given the mixed treatment, and locally mercurial plaster was used with some benefit. From July until the middle of August, the affected parts were painted with pyrogallol, forty grains to one ounce of collodion, the mixed treatment being continued, and the improvement was very marked. From the middle of August to the first of October, she was without any treatment, and the disease grew worse, but improved again under the internal treatment and pyrogallol until October 26, when the mixed treatment disagreed with the stomach, and it was discontinued. From now on to December 15, when she was last seen, pyrogallol alone was used, and the improvement was more marked than under the internal treatment.

The points of interest in the case are: 1st, that two months previously to December 15, when he had showed the case to the Society as a possible lupus, only local treatment with pyrogallol had been used, and the disease was almost cured

under it alone. The question arose whether a syphilis would have been so benefited by local treatment, or whether the good results were due to the mixed treatment which the patient took from June to October without much benefit to the nose during the time.

2d, That when patient was last seen, in December, the appearances were very much those of a lupus. There were some reddish-brown papules, somewhat pulpy, and some yellow points in the infiltrated tissue, which broke down easily upon being bored into. The surface of the patch was covered with fine epidermic scales.

3d, That the absence of a specific history and of other lesions and symptoms made it appear like a lupus hypertrophicus.

4th, That now, after an absence of over three months, the patient returns with the warty, exuberant growth again developed upon the sides of the nose, and ulceration extending into the nostrils. She now complains of osteocopic pains in the head, chest, and legs, worse at night, and under pressure and concussion, soreness of throat, and roof of mouth. Examination shows a deposit in the soft palate, which is probably gummy, and in which ulceration has begun. These signs, which were before absent, now do away with any doubt that may have existed as to the diagnosis.

Dr. TAYLOR questioned very much whether the lesion was a syphilide, because it had lasted so long and with so little destruction of tissue; still that, of itself, would not invalidate the diagnosis of syphilis.

Dr. JACKSON said that it reminded him of the case of rosacea hypertrophica that he had presented to the Society a short time ago. In that case, the lesion improved at first under local treatment, but afterward broke down and ulcerated, and finally disappeared when the mixed treatment was given, and iodoform applied locally.

Dr. ALLEN said that in this case the cauliflower-like eruption formed exuberant granulations, which did not cause so much destruction as in other forms of syphilitic lesions.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

The Pathogeny of Dermatoses.

IN beginning this letter, I cannot resist the inclination to indicate in a few words the great importance of the new chemical researches of M. Gautier (presented before the Paris Academy of Medicine, Jan. 19, 1886), in their bearing upon the pathogeny of diseases in general, and of diseases of the skin in particular. For some time past, I have already, in several articles, expressed myself in accord with my friend, Dr. Barthélemy, that the explanation of many dermatoses of obscure origin was furnished us by the eruptions which develop after the ingestion of certain substances, especially the medicaments. In the latter case, it must be admitted that the noxious foreign element, after having been absorbed and taken up in the circulatory current, goes to act either upon the nervous system or directly upon the integument, and develops an eruption quite characteristic in the majority of cases, for the noxious substance is promptly eliminated. We in-

sist that it would be quite logical to admit the same pathogeny for a large class of eruptions, especially for rebellious and recurrent eczemas, which are so frequently observed in certain persons, especially the gouty.

We believe that they are caused by the accumulation in the blood of these patients of the products of incomplete assimilation, tending to the impoverishment of their nutrition, products which must of necessity be injurious to the organism.

The researches of M. Gautier confirm our theory in a novel manner. For some time we have known that after death there are produced in the cadaver toxic alkaloids, to which are given the name of ptomaines. M. Gautier has demonstrated that in our organism, even during life, there are likewise produced alkaloids more or less toxic, more or less injurious, to which he has given the name of leucomaines, and which, when not destroyed by the oxygen of the blood or eliminated either by the kidneys or alimentary canal, may, by thus accumulating in the economy, occasion morbid phenomena. Let any cause whatever, then, hinder hematosiis, diminish the oxidating power of the hematics, interfere with the eliminating action of the various emunctories of the body, and soon the blood, surcharged with toxic principles, will find itself, in relation to the skin, precisely in the same condition as if it had been vitiated by the ingestion of a medicinal substance capable of promoting an artificial eruption.

For my part, I have come to the conclusion that, from the point of view of this pathogeny, the diseases of the skin of actually known origin may be divided in four grand classes.

1. Artificial eruptions from mechanical, external cause, or eruptions directly provoked.

2. Artificial eruptions from internal cause or provoked indirectly—the pathogenetic affections of Bazin—resulting from the ingestion of alimentary or noxious medicamentous substances.

3. Eruptions depending upon the vitiation of the blood and of the entire economy by the leucomaines.

4. Eruptions of parasitic nature, animal or vegetable parasites and microbes, bacilli in particular.

I do not believe, as one of our savant professors asserted before the Academy of Medicine, that the discovery of leucomaines will prove to be the death-blow of microbian theories; I believe that the two discoveries complement each other. It is not possible to explain all by the microbes alone, or by the leucomaines alone. But in admitting the reality of these two grand causes of disease, the pathogeny of nearly all diseases seems to us clear, logical, rational, established upon a basis almost impregnable.

Eczema in the Gouty.

I am all the more disposed to admit that the leucomaines or other products, of whatever nature they may be, morbidly found in the economy, intervene in the pathogeny of certain dermatoses, since, faithful to the old French doctrines of Hospital St. Louis, I have always believed and always contended that the diseases of the skin could not in all cases be considered as purely local lesions. On this account, I cannot too highly approve of the recent communication of Dr. Deligny upon Eczema of the Gouty (*Union Médicale*). He there shows that there exist incontestable relations between certain dermatoses and certain general states, especially of an arthritic nature. He has observed distinct alternations between

cutaneous eruptions and visceral phenomena, bronchitis, attacks of articular gout, neuralgias, attacks of asthma, etc. . . . He has, moreover, observed that eczema in the gouty does not become tenacious, chronic, rebellious to local medication, until the period of life when these patients begin to present evidences of dyspeptic trouble, that is, from 25 to 35 years of age. Now it is quite pertinent to inquire if the incomplete digestion does not facilitate the production in the organism of the noxious elements of which I have already spoken.

Abandoning now these questions of pathogeny as, perhaps, somewhat too abstract at first glance, but which, nevertheless, are of the greatest practical importance, since the rational treatment of these rebellious dermatoses depends upon their correct understanding, we may say that, according to Dr. Deligny, eczema of the gouty resembles eczema of the rheumatics; the lesions are dry, rarely exudative, squamous, circumscribed, especially affecting the discoid or orbicular form. It is much oftener observed in men than in women; it is situated especially upon the head (face and hairy scalp in nine of thirty-six cases), and at the anus (in thirteen of thirty-six cases). He thinks that its frequency in this latter region should be attributed to the anal pruritus so common in these patients, to the scratching which it occasions and to the irritant applications which are continually applied for its relief.

As to treatment, Dr. Deligny is quite pronounced. According to his experience, which embraces about one hundred and forty cases of gouty eczema, he believes that alkaline medication gives by far the best results. It is quite otherwise, he adds, in the case of eczema occurring in rheumatics; in this class of patients alkalies often fail. It is not, then, a matter of indifference whether a gouty patient with eczema is sent to an alkaline or to a sulphurous mineral spring. There are cases in which irritability of the skin or other individual conditions will not admit of the employment of fresh alkaline mineral waters; it is then necessary to have recourse to chlorinated sulphur waters.

Treatment of Psoriasis with Chrysophanic Acid.

Drs. du Cazal and Boutonnier have recently published two articles (*Archives de Médecine et de Pharmacie Militaire*) upon the treatment of psoriasis by chrysophanic acid, which they employ either in ointment, according to the older method, or in solution in chloroform, after Besnier's process. This last method consists, as indicated in a previous letter, in scraping off the scales in a bath, then painting the patches with a fifteen-per-cent solution of chrysophanic acid in chloroform, and covering them with a layer of traumaticine. These applications are made every second or third day. By this mode of treatment they succeed in causing the disease to disappear in from fifteen days to five weeks. The results are by no means unusual, and I should not have referred to these articles had they not contained an opinion which appears most surprising. Having never observed a recurrence of the disease after the chrysophanic acid treatment, these authors conclude that this dermatosis should not be regarded as a rebellious disease, and should not be the occasion of a reduction in the regiments, and of exemption before the councils of revision. Certainly there are, in my opinion, patients with psoriasis who may well be retained in the military service, but I cannot accept the statement that by chrysophanic acid treatment psoriasis may be regarded as a tractable and curable disease. Psoriasis is, on the contrary, it hardly need be said, the recurrent dermatosis *par excellence*. There are patients who have only a single crop of eruption, but how much more numerous are those in whom it re-

establishes itself with the greatest tenacity. Experience has long since demonstrated that we cannot regard a psoriatic patient as cured when we have simply cleared the surface, whatever may have been the method of treatment employed. In my experience with chrysophanic acid in psoriasis, I have been especially impressed with the variability of the results obtained in different cases, which, no doubt, depend partly upon individual susceptibilities, and partly upon the quality of the chrysarobin. Sometimes this agent acts most energetically in small doses, sometimes it develops a most intense erythematous eruption, sometimes it appears almost inert. I have often seen recurrences in patients whose skin has been perfectly cleared by this treatment. At the present time, we possess many agents (goudron, naphthol, oil of cade, pyrogallic and chrysophanic acids) and many therapeutical processes (ointments, traumaticine, medicated collodions, with addition of salicylic acid, etc.), which are really efficacious in causing the disappearance of the psoriatic patches, but which are powerless against their return. Arsenic and arsenical waters seem to be the best, or the least objectionable, means we can employ for this purpose; but they are far from being infallible. The more I observe the course of this disease, the more I am convinced that it should not be considered a purely local affection of parasitic nature, as Drs. Lang and du Cazal contend. I believe that, like certain eczemas, it is in the large majority of cases an external manifestation of a constitutional state of certain predisposed individuals, and I am persuaded that dermatologists should seek to find a radical cure, if this be possible, in an internal treatment, with appropriate regimen.

Vulvar Pruritus.

Dr. Martineau has published a lecture (*Annales Médico-Chirurgicales*) upon vulvar pruritus, in which he gives to practitioners certain advice in regard to the best mode of treatment of this painful and rebellious affection. First of all, it is important to ascertain the cause of the disease; for, in order to treat it intelligently, it is necessary: 1st, to treat the constitutional malady, the original source of the accident; 2d, to treat the lesion, the immediate cause of the pruritus; 3d, to treat the morbid phenomenon, the pruritus. We should determine whether the patient is tuberculous, lymphatic, neuropathic, arthritic, diabetic, etc.; then, whether there exists any parasitic affection, as intestinal worms, oxyures, pediculi pudendi, herpes tonsurans; whether there are vesical or urethral disorders, etc.; and the genital organs should be carefully examined, the vulva, vagina, and uterus, since vulvar pruritus is often symptomatic of metritis, of vaginitis, of contagious vulvitis, or it may be consecutive to eruptions of psoriasis, lichen, zona, and especially herpes. Finally, vulvar pruritus may be purely of nervous origin, and occur without any apparent lesion of the integument; in nervous or arthritic women, any moral impression, or simple change of temperature, may suffice to develop it.

After this preliminary, but quite necessary investigation, one is prepared to treat the pruritus intelligently and successfully. A treatment appropriate to the constitutional condition and the local lesion may then be instituted, although, as intimated above, we must rely upon local means to palliate the almost intolerable intensity of the morbid phenomenon. When there is an acute inflammation, as in vulvitis, emollients, poultices of potato starch, lotions with infusions of belladonna, aconite, or poppy heads should be employed, or a solution of bromide of potassium or chloral. Dr. Martineau recommends that the lotions be applied rather warm than cold. The poultices may be replaced by compresses of

fine linen saturated with a decoction of leaves of elder or myrrh. When the acute stage has subsided, weak lotions of the sublimate may be employed, two or three times a day. Sometimes slight cauterization with nitrate of silver will be found serviceable; sometimes the application to the vulva of compresses dipped in a slightly acidulated water affords relief. At night, if there is irritation of the integument, it may be smeared over with an ointment composed of 50 grams of glycerole of starch to 1 gram of either tannin, calomel, ext. belladonna or oil of cade, according to circumstances.

In chronic cases, Dr. N. Guéneau de Mussy makes lotions with the following: Infusion of marsh mallow, 1 litre; cherry-laurel water, 50 grams; subborate of soda, 10 grams. He then prescribes an ointment to be used night and morning, as follows: Glycerole of starch, 20 grams; bromide of potassium and subnitrate of bismuth, $\bar{a}\bar{a}$ 1 gram; calomel, 40 centigrams; extract of belladonna, 20 centigrams.

Delioux de Savignac uses the above lotion, and then dusts the surface with the following powder: Pulv. lycopodium, 30 grams; subnitrate of bismuth, 19 grams; belladonna root, 2 grams. Sometimes good results are obtained by sprinkling the vulva with iodoform.

Since the discovery of cocaine, it has been employed in all painful affections of the mucous membranes, and especially in vulvar pruritus. Dujardin Beaumetz has been able to obtain a prompt anæsthesia of the vulva by painting the parts with a one-fiftieth solution of this drug. In my experience, I have found that an almost intolerable pruritus, symptomatic of herpes of the vulva, may be relieved by applications of an ointment of cocaine ($\frac{1}{15}$ to $\frac{1}{15}$).

Treatment of Gonorrhœa with Antiseptic Injections.

Dr. A. Bourgeois has recently published (*Archives de Médecine et de Pharmacie Militaires*) an important article on the treatment of gonorrhœa with antiseptic injections. Since the microbiologists have affirmed the existence of a gonococcal cause of gonorrhœa, the whole problem, in the author's opinion, consists in finding an antiparasitic topic, sufficiently energetic, but innocuous to the mucous membrane. It is thus necessary to lay aside all very irritating substances; the three parasitocides which seem to him to unite all required conditions are permanganate of potash, bichloride of mercury, and sulphate of quinine. He employs the permanganate in solution (1 to 2,000), the bichloride (1 to 20,000), the sulphate of quinine (1 to 100). Four injections are to be made in twenty-four hours, one in the morning, one at noon, one at seven o'clock in the evening, and the other during the night; this last is indispensable, according to Dr. Bourgeois since, if the microbes be left to repose during the entire night, they will have time to multiply. The injection should be warm, as it thus penetrates more easily into the urethra; it should not occasion pain; if so, it should be diluted until it can be well tolerated. A glass syringe, well graduated, capacity of eight grams, should be used. The injection should be made to entirely fill the urethra, but not to forcibly distend it and produce pain and perhaps injury to the mucous membrane. It is much better to use colored liquids, since one can thus better judge of the quantity introduced into the urethra. After having diluted the first injections, the patient will gradually get accustomed to the full strength recommended above. The patient should be directed to urinate one-quarter of an hour before, and as long as possible after the injection.

In order to insure the penetration of the medicated liquid to the desired depth,

Dr. Bourgeois has devised another procedure, which consists in introducing within the urethra, to the depth of about eight centimetres, a cylindrical gum sound of medium calibre, open at its two extremities, without lateral eyes. This is first smeared with iodoform ointment (1 to 20), and a glass syringe, holding eight grammes of the injection, is filled to its free extremity, and the liquid is gently forced into the urethra, the instrument being at the same time gradually withdrawn, so that the liquid replaces the sound in the canal, where it is retained from ten to fifteen minutes. Two or three such operations should be made in the course of twenty-four hours. In addition, the author gives to his patients, during the entire course of the disease, one to two grams per day of bromide of potassium, with a view of preventing all genesic excitement. He also treats the constitutional condition of his patients with appropriate medication.

Gastric Syphilis.—Rickets and Hereditary Syphilis.

Among the numerous interesting publications which have recently appeared in France upon syphilis, I may direct the attention of your readers to two mémoires of Dr. Gaillard, one of which refers to the possibility of the occurrence of ulcerous lesions of the stomach, of syphilitic origin, and consequently curable by mixed treatment (*Archives Générales de Médecine*, Jan., 1866); the other in which he shows, by the most convincing facts, that rickets may be considered, as claimed by Parrot, one of the manifestations of hereditary syphilis (*France Médicale*, Jan. 7, 1866).

L. BROCCQ.

PARIS.

Selections.

THE CONTAGIUM OF SYPHILIS.

A PRACTICALLY complete series of experiments on the carrier of the contagion of syphilis will be published in the transactions of the *Tokio Daigaku*.

The most important results arrived at by the authors, Dr. Disse and Dr. Taguchi, are here given.

1. In the blood of syphilitic individuals are found spores, which can be demonstrated in specimens of blood from the living person, stained with the necessary precautions, dried on a cover glass, and preserved for a time in absolute alcohol. For the most part, the staining method of Gram is recommended (*Fortschritte der Medicin*, Bd. 2, 1885).

2. In the secretion of flat condylomata, as also in the primary induration, the spores are found altogether similar, and numerous short baccilli are also present, which are made visible by the same method as the spores in the blood.

3. In the blood of syphilitics, under treatment for secondary symptoms, are found bacilli as well as spores, partly in the leucocytes.

4. If you introduce a small quantity of fresh blood, drawn with all necessary precautions from a syphilitic individual, into a solid culture field (culture gelatin peptonized broth with agar-agar, blood serum), there develops within a few days, at a temperature ranging from 18 to 40° Celsius, a pure culture of peculiar bacilli, which actively form spores.

5. In neutralized meat broth, it is observed that these bacilli show extraordinary active movements at a temperature of 32°, and slower movements at a temperature of 16° Celsius. Here also is to be seen the capsule, which, in stained preparations from culture gelatin and blood serum is not so easily discernible. In their movements, the bacilli often become curved or bent, and those containing spores often take on the appearance of heaped up micrococci. In hanging drops of meat broth, the bacilli remain at the summer temperature of Tokio (about 30° Celsius during the months of July and August), for five days and longer full of life and motion.

6. From the blood of a cadaver, on which were found signs of syphilis, the same cultures were obtained as from the blood of living syphilitic subjects. A pure culture was obtained, twenty-seven hours after death, from a specimen of blood taken from a vein of the brain.

7. Blood serum does not become fluid from a culture with syphilitic blood. The culture forms a whitish thread following the inoculation, which quickly spreads over the free surface of the culture field in the form of a white coating. Cultures in gelatin or broth peptone with agar-agar will become fluid after a few days in the neighborhood of the inoculation, spreading out from the surface.

8. Kept in the room in Japan, during the summer months, the cultures develop as rapidly as in the culture oven.

9. A culture in blood-serum was found entirely active after four months.

10. Inoculation with such pure cultures will infect rabbits, white mice, dogs, sheep, etc.

11. At the point of inoculation there is a slight induration, which, however, does not inflame. In one case (rabbit), the induration became as large as a pea, remained from eight to sixteen days, and then gradually disappeared. In the blood of all the inoculated animals were found spores and bacilli, and spores in process of formation. In every case, the spores resembled those of the culture used.

The quantity of micro-organisms was proportionate to the time which had elapsed since the inoculation. At first, the spores and bacilli were free; later, they were found in the white and red blood-corpuscles.

12. From the blood of the inoculated animals, pure cultures were made, which resembled in all cases those obtained from the blood of syphilitic men.

13. Inoculation with cultures from the blood of inoculated animals was followed by the same results as those from the human-blood cultures.

14. In a pregnant rabbit, killed two months after inoculation with a culture from human blood, the blood of the foetus, carried almost to term, was found filled with the same bacilli and spores as the mother's blood. A portion of the bacilli were inclosed in the leucocytes.

15. In the mucous membrane of the uterus of the rabbit referred to, was found one large (30 millimetres long and 20 millimetres broad) and several smaller, white, prominent nodules of a round form, which were found to be principally made up of a cheesy mass in which many necrotic cells were still to be seen. The mucous membrane and glands were entirely destroyed in these masses, and only a few blood-vessels could be found in the detritus.

In the placenta was found a yellowish-white nodule measuring 12 by 9 millimetres, and 5 millimetres thick, proceeding from the chorion, and attached to the foetal side of the placenta. The cheesy mass of which it was made up contained here and there groups of cells, which resembled decidual cells. All the placentas were diffusely affected.

16. In the livers of the rabbit mentioned, and of one other likewise killed after two months, several gummata were found, some as large as a pea. In the bronchus of one, there was a cheesy nodule proceeding from the mucous membrane. There was no tubercular deposit.

17. In the gummata of the liver, as well as in the cheesy nodules of the mucous membrane and of the placenta, were found a few bacilli and spores which resembled those of the blood. These were at once brought out by staining the section after Gram's method.

18. Aside from a slight loss of flesh, the inoculated animals showed no signs of sickness. The most of them (dogs, sheep, and several rabbits) are still under observation. On October 12, a rabbit died which had been inoculated on June 2. The post-mortem showed syphilis of the lungs, stomach, and skull. The observations were begun in March, 1885. As the first cultures and inoculations were made, we received an account of the observations of Lustgarten (*Lancet*, April 4, 1885).

As, up to the present time, the larger illustrated work prepared by this author has not been received, we are not prepared to say whether the bacilli found by us are the same as those Lustgarten discovered in the products of syphilis in the human subject.—*Deutsche Med. Wochenschrift*, No. 48, 1885.

DIFFERENTIAL DIAGNOSIS OF SYPHILIS AND SCROFULA.

In syphilis all is change and variety; in scrofula all is fixed and immutable. The cutaneous lesions of syphilis are migrating; the lesions of scrofula are riveted, so to speak, in their primary place which they never quit; and this fixity of situation, during a prolonged period, often many years in duration, will suffice to distinguish them from the *syphilides*, which are ambulatory, and which appear in successive crops and upon different regions of the body.

The lesions of syphilis are *intermittent* in duration; the lesions of scrofula are essentially *permanent*, and this absolute *continuity* during five, ten, fifteen years will suffice again to distinguish them from syphilides, which appear and disappear at intervals more or less distant.

Syphilis is a Proteus; it manifests itself upon the skin by the most diverse lesions; in the same patient, at different periods of its evolution, it presents the most different aspects, because the lesions which represent it are most numerous and diverse. In scrofula, on the contrary, it is always the same lesion; there is only one form one day to another.

In syphilis we have, then, *variety of situation, variety of duration, variety of lesions*; in scrofula, *fixity of situation, fixity of duration, fixity of lesions*.

Syphilis has its special coloration, a deep-reddish brown; scrofula its also, a light raspberry-red; vinous tints disposed in large, prominent, and neatly limited patches.

Syphilitic lesions develop over the entire surface of the body, it does not spare any region; the lesions of scrofula are rarely found except upon the face, and particularly upon the nose and cheeks; they scarcely ever descend below the neck.

Syphilis is hereditary, virulent, inoculable, and contagious by direct contact; scrofula is likewise hereditary, but it is neither virulent nor contagious by direct contact and inoculation.

Syphilis affects all ages, all temperaments, all constitutions; scrofula rarely develops before the fourth or fifth year; and in order to develop, there is necessary a special *terrain*, a particular constitution, a *scrofulous temperament*. This

temperament is revealed by certain special characteristics: the head disproportionate in size to the rest of the body; alæ of the nose thickened; nose flattened, large; nostrils incrustated; eyes bleared; mouth widely slit; lips thick; the transverse diameter of the face larger than the vertical; neck voluminous and as if engorged; legs short: the *ensemble* of the body without harmony, ungraceful; intelligence slightly developed.

The lesions of scrofula are not more painful than those of syphilis; but while the syphilides are ordinarily accompanied with slight fever and constitutional disturbance, the severest lesions of scrofula occasion no disorder in the physiological exercise of the animal functions.

The syphilitic ulcer is regular in contour, as if punched out; the scrofulous ulcer is irregular, its edges are jagged and detached.

In its work of destruction, syphilis proceeds from the deep to the superficial parts: scrofula follows an inverse course; it begins by destroying the skin before destroying the cartilages and bones.

Scrofula in its period of development, and when stationary, always produces hypertrophy of the parts which it involves; and in its period of decline it atrophies the same parts; it leaves the nose sharpened, lanceolate, and the opening of the nostrils retracted and obliterated. When scrofula gets well, it is followed by hideous deformities, always irremediable. The cicatrices of all its lesions are indelible, like those of syphilis; but while the latter are pale, colorless, smooth, and not adherent to the parts beneath, the cicatrices of scrofula are, on the contrary, irregularly violaceous, reticulated, seamed, anfractuous, and intimately adherent to the subjacent tissues.

All the scrofulides are *malignant* lesions; they all disorganize the skin in different degrees, and often destroy the organs and the bones. Their duration is always essentially chronic.—M. GUIBOUT, *Gazette des Hôpitaux*, No. 74, 1885.

TUBERCULOSIS VERRUCOSA CUTIS.

It is only in very recent times that tuberculosis of the skin has been studied, and as yet but few cases have been reported. Drs. Riehl and Paltauf (*Viertelsschr. für Derm. und Syph.*, 1886, xiii., 19) now designate with the above title an, as yet, underscribed form of the disease, as they claim. This study is upon a number of cases seen in Kaposi's wards in Vienna. The disease attacks persons of both sexes, but especially men; is found on the back of one or both hands, sometimes on the flexor surfaces of the fingers or between the fingers, rarely on the palms or adjacent parts of the forearm. It occurs in patches, varying in size from that of a lentil to that of a silver fifty-cent piece; in shape either round or oval, or serpiginous when several join at their edges. These enlarge at their peripheries by the deposition of new primary lesions, so that in all patches of old standing the edge will present the appearances of the primary efflorescences, while the central part will be at its height or undergoing resolution. A developing patch will be surrounded by an outer erythematous band a few millimetres wide, of a bright-red color, which disappears fully under pressure, and is scarcely raised above the *niveau* excepting on its inner part. It is smooth and often glossy, with the mouths of the glands and follicles plainly recognizable. Inside of this band there is often another zone composed of small lentil to hemp-seed superficial disseminated pustules with thin covers, or of numerous crusts or scales, remnants of the same. This zone is brownish or livid-red in color, which passes under pressure with a yellowish tinge, showing the presence of infiltration

Nearer the centre the surface of the patch becomes more raised, and irregularly uneven, the unevenness increasing centrally into warty growths with club-shaped or more pointed ends—papillomas, some of which are five to seven mm. high. The surface of this central part is generally covered with crusts. Between the papillomas are rhagades, small erosions, or pustules, and when the patch is squeezed numerous drops of pus escape from between the warty excrescences. The patches are occasionally acutely inflamed. This is the height of the affection.

Retrogression is shown by a flattening of the papillomas toward the middle of the patch, a lessening of the crusting, and disappearance of the little abscesses. In very old patches the centre is even, has no papillomas, is smooth, or slightly scaly, or of cicatricial appearance. The cicatrices are located chiefly in the papillary layer of the skin; are thin and supple, and have a sieve-like or fine net-form appearance.

The only subjective symptom is a feeling of pressure during the developmental stage of the disease, which sometimes on contact increases to a feeling of pain. The subjects of the disease all were more or less occupied in caring for animals or handling meat.

The disease is chronic, advances slowly, and apparently is unlimited in its growth. A patch will be at its height one or two months before the papillomas begin to flatten.

The *diagnosis* is made upon the course of the disease as a whole, rather than upon any particular characteristic symptom. It differs from *lupus* in not having brown-red nodules, and in its advance being accompanied by inflammatory symptoms; in showing no tendency to ulceration, nor to return in its cicatrices. While *lupus* hardly ever occurs after puberty, this form of tuberculosis occurs after puberty. It differs from *simple inflammatory papillomas* in not being so inflammatory, and in being slow in development. From *frambæsiiform syphilis*, it is diagnosed by the absence of the hard, brown-red infiltration of its edge, and by its history.

Histologically, the disease presents in its infiltration the peculiarities of giant-cell tubercular infiltration. Tubercle bacilli were also found in the giant cells and in other places.

The *prognosis* is good when properly treated. The *treatment* consists either in excision or curetting, followed by cauterization. They found curetting followed by application of caustic potash, or silver nitrate, or in combination with iodoform dressing, the best method of treatment. The galvano-cautery is also a good method of treatment.

CONTRIBUTION TO THE STUDY OF THE PATHOGENY OF HERPES PHLYCTÆNOIDES.

THE eruptions of phlyctænid vesicles, commonly called *herpes phlyctenoides*, appear to form two categories.

The one, which we shall call *microbic herpes* is produced by the elimination through the skin of micro-organisms, either non-pyogenic or but slightly so.

This category includes *black herpes*—a variety which has points of resemblance with *zona* (Erb, Landouzy). You can also place alongside of this variety the vesiculations of *variola*, of *malignant pustule*, and of *erysipelas*.

This variety of herpes, which could also be called *septic herpes*, appears to be caused by a microbic infection, of which the particular infecting agent is un-

known to us, the production of a cutaneous or mucous vesicle being but an epiphenomenon of a severe general morbid state.

The second category of herpes phlyctenoides includes *ptomainic herpes* (Boucheron), which has as immediate cause the determination to the skin or the mucous membrane of materials of the nature of animal alkaloids, or vesicating *zoamines*.

This herpes can appear under a great number of circumstances. It may be, for example, a sequence of irregularities of regime, of muscular or nervous overwork, of violent emotion, and of certain menstrual states. It may also appear in those undetermined conditions which correspond to the general morbid state clinically called *herpetic* or *arthritic*.

a. In a predisposed individual, an irregularity of digestion may be followed, in thirty-six or forty-eight hours, by an herpetic vesication affecting some region of the skin or of the mucous membrane. We believe that in this case the alimentary materials taken in excess not having been sufficiently elaborated or oxydized, there has resulted a series of residues—some well known, as, for example, uric acid; others with which we are not sufficiently acquainted, as the ptomaines and alkaloids, substances of which the nature is, from a chemical point of view, to be irritant in a high degree. Insufficiently expelled by the normal channels of elimination, these substances find themselves, at a given moment, in too great quantity in the blood, and take an abnormal course of elimination, thus causing vesicles of herpes.

b. Herpes following muscular or nervous overwork results equally in an excessive production of organic waste products which the natural emunctories are not able to eliminate, and which seek an exit by the way of the mucous membranes.

c. In herpes produced by emotional shock or by cold, there are in addition inhibitory phenomena (Brown-Sequard), or arrest of elimination of waste products by the natural channels, which likewise seek abnormal ones.

d. Menstruation, having besides its physiological function the pathological one of elimination of materials in excess in the organism, it can, when arrested, give rise to a variety of disturbances, among which herpes may be observed.

e. All the causes above enumerated play only an incidental rôle, the determining cause being the arthritic state of the individual. Arthritic subjects—that is to say, those having the pathological conditions necessary to the production of vesicating material, should :—

1. By a dietetic régime suitable to their case avoid the production of these vesicating substances in excess.

2. By following hygienic laws and therapeutic measures, favor the elimination of vesicating substances by the natural emunctories.—*Th. de Paris.*

LEUCODERMA SYPHILITICUM.

Nordiskt Medicinskt Arkiv, vol. xvii., number 3, contains an article of thirty-one pages on syphilitic leucoderma, by Dr. Alex. Haslund, Visiting Physician to the City Hospital of Copenhagen, Denmark. With special regard to this disease, the author examined all patients admitted to the Hospital during four months. Of 83 men, 25, or 30.1 per cent, had leucoderma; of 122 women, 80 had it. The disease is characterized by the light-colored round spots. The intervening skin may be normal, but is often the seat of a dark pigmentation. The latter can be made to fade by means of bichloride of mercury, but there is no remedy for the light spots. The affection is very chronic, and may last for years. They are decidedly of syphilitic origin. Each spot appears only where there has been a

macular syphilide. He has never seen them after papular eruption. The white spots sometimes found after papular syphilides are only the remnants of the papules themselves, quite level, white cicatrices due to a real change in the tissue of the skin, whereas in leucoderma the skin is normal, only deprived of pigment.

The diagnosis is easy.

The affection is not a symptom of syphilis, but a sign that the individual has had macular syphilides.

Of the 25 men, 5 only had occupations in which they often were exposed to fire, 13 had dark hair, 12 were blonde.

Of the 80 women, 37 had dark hair, and 43 light hair. Thus, neither exposure to irradiating heat, nor the color of the skin, as claimed by some authors, seems to have any influence in the production of leucoderma.

HEMORRHAGES IN SYPHILIS.

THE following are the conclusions reached by Drs. Hartmann and Pignot from a study of hemorrhages in syphilis (*Annales de Dermat. et de Syphilig.*, January, 1886).

A. In congenital syphilis a true hemorrhagic diathesis is observed.

B. In acquired syphilis

1. Nothing proves that the diathesis exercises its influence upon the production of hemorrhages on the surface of simple wounds.

2. Even in the cases where the cutting instrument encounters tissues altered by the disease itself, serious hemorrhage is exceptional.

3. Specific ulcerations simply give rise to slight oozing of blood. Those cases must be excepted in which, by an extension of the morbid process, an important vascular branch is destroyed.

4. By the intervention of an arteritis which it produces, syphilis may be the cause of visceral hemorrhages, especially in the brain. The paroxysmal form of hæmoglobinuria frequently has syphilis as a cause.

According to Murri, the changes are explained by a morbid state affecting at the same time the organs producing the globules and the vaso-motor centres.

5. Syphilis may determine cutaneous hemorrhages, *a*, on the surface of specific eruptions; *b*, in producing a special form of purpura; *c*, in acting as a determining cause of a purpura presenting its usual characters, but appearing in the period of secondary syphilis.

CONTRIBUTION TO THE STUDY OF ZOSTER FEVER, INFECTIOUS ZONA.

1. THE distinction must be made between zoster and zosteriform eruptions.

2. Zoster is an acute febrile disease.

3. This affection, by reason of its evolution and of a certain degree of contagiousness and tendency to exist epidemically, should be classed among the general infectious diseases.

4. The localization of the eruption on the course of a nerve, and the lesion of the nerve ganglia lead to the belief that the affection is a neuropathy.

5. This ganglionic neuropathy is probably due to the presence of a specific micro-organism.

6. The etiology, the evolution, and the unity of zoster separate, in a marked and well-defined way, this affection from diseases having similar vesicular eruptions—the zoster-like exanthemata and herpetic fever. — DR. L. BOULANGER, *Th. de Paris*, 1885.

Books and Pamphlets Received.

Lehrbuch der Haut- und Geschlechtskrankheiten für Studierende und Aerzte, von DR. EDMUND LESSER, Privat-Docent an der Universität Leipzig. Will be noticed in subsequent number.

Le la Sarcomatose Cutanée, par DOCTEUR LEON PERRIN, Ancien Interne en Médecine et en chirurgie des Hôpitaux de Paris. Will be noticed in subsequent number.

La Lèpre doit-elle être Considérée comme une Affection Contagieuse, par le DR. BROCCQ. Reprint.

Ein Fall von Ringelhaaren, von DR. EDMUND LESSER. Reprint.

Ein Fall von Lichen Planus chronicus trunci et extremitatum, von DR. C. SCHADECK. Reprint.

Ein Fall von Leucoderma Syphiliticum, von DR. C. SCHADECK. Reprint.

Zur Casuistik des Herpes iris universalis, von DR. C. SCHADECK. Reprint.

Zur Casuistik der syphilitischen Erkrankungen des Nebenhodens, von DR. C. SCHADECK. Reprint.

On the Affections of the Skin Induced by Temperature Variations in Cold Weather, by DR. J. NEVINS HYDE. Reprint.

Alopecia Areata: its Etiology, Diagnosis, and Treatment, by GEORGE THOMAS JACKSON, M.D. Reprint.

The Nervous Symptoms of So-called Lithæmia, by LANDON CARTER GRAY, M.D. Reprint.

The Third Annual Report of the New York Skin and Cancer Hospital shows this institution to be in a flourishing condition. It appears that 1,064 patients have been treated since the last annual report. About 140 of these were cancer. In addition to the City Hospital, this institution has a country branch of cottage pavilions, just opened at Fordham Heights. This Charity is doing a noble work, and merits the confidence and support of the profession and the public.

Items.

OINTMENT FOR SYPHILITIC PSORIASIS.—Mauriac recommends, as a local application in syphilitic eruptions on the palms and soles :

R Ol. cadini,

Ung. hydrargyri.....ãã ʒ ss.

Vaseline.....ʒ i.

COPAIBA SUPPOSITORIES IN VAGINITIS.—The *Bulletin Gén. de Thérapeutique* says Prof. Ball has successfully treated acute inflammation of the vagina with suppositories of seventy-five grains of copaiba and cocoa butter, and three-fourths of a grain of opium. The suppositories are allowed to remain twelve hours. In twenty days the patients are entirely cured.

POISON IVY ERUPTION.—An excellent remedy is said to be an infusion of the sweet fern (*Comptonia Asplenifolia*). This is rubbed freely all over the affected surface, and left to dry. The slightly yellowish stain left by its application wears off in a few days.—*Exchange*.

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Original Communications.

SOME REMARKS ON THE DIAGNOSIS AND TREATMENT OF
SPASMODIC STRICTURE.

BY

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ORGANIC strictures of the deep urethra are very rarely met with, as all surgeons assure us, but contractions dependent upon irritation reflected from the anterior canal are of common occurrence. The presence of a stricture in the pendulous urethra, or the existence even of a contracted meatus urinarius, often occasions, as a result of reflex irritation, a contraction at the membranous junction so resistant that a filiform bougie cannot be passed beyond it.

Such spasmodic action of the muscular urethra may result from other causes than the existence of organic strictures in the anterior urethra. A spasm is occasionally produced in the membranous portion by the simple passage of an instrument along the urethra, which acts solely as an irritating medium to the mucous membrane, precisely as an irritation may be occasioned by highly acid urine.

Voluntary retention of urine for a prolonged period is also capable of exciting spasm. Diseases of the rectum and all irritations about the anus, as well as derangements of the digestive or cerebro-spinal system, may produce urethral spasm.

A slight urethral discharge is, generally, an early and constant symptom of stricture. Such a urethral discharge might arise from causes independent of stricture, but the continued presence of a gleet may be

justly regarded as symptomatic of a contraction in some part of the urethra.

Among other important symptoms of stricture may be mentioned a more or less frequent desire to urinate, associated with lumbar pain, sometimes extending from the back around both sides to the inguinal regions and down the scrotum, following the course of both ureters and the spermatic cord. Pain is also referred, occasionally, to the suprapubic region, or in the perineum and along the urethra before, during, or after urination.

A sharp pain is not infrequently experienced at the end of the penis after the bladder has been emptied. This is, I think, oftener observed when a spasmodic condition of the membranous urethra exists, or rather has a tendency to be excited to spasm as the result of a permanent stricture anterior to the bulb.

The stream of water is more or less altered in size, momentum, and form. It may assume a spiral shape, may be expelled from the meatus in two or more distinct streams, or the patient may be obliged to make strenuous efforts to urinate, without avail. This symptom is more likely to be present when permanent strictures complicate the spasmodic, but the symptom may also be an indication of the latter condition alone.

When urine manifests an ammoniacal condition, the presence of stricture may be suspected. A partial retention of the urine is thus occasioned by the incomplete emptying of the bladder, and the retained portion is prone to decompose, thus exciting troublesome cystitis if the obstruction is not removed promptly.

Prof. F. N. Otis has often demonstrated the frequency with which strictures of the deep urethra are found to co-exist with a contracted meatus urinarius only. They have been shown to be dependent not infrequently upon the presence of strictures of large or small calibre in the penile urethra. No surgeon merits more credit than Prof. Otis for recognizing and proving the correctness of these facts by the results of many such operations for the relief of spasmodic strictures.

In the course of my experience I have met with not a few instances where a contracted orifice or stricture of large calibre situated in the penile urethra was the sole cause of what seemed to be an impassable stricture of the deeper portions of the urethra.

Some eminent surgeons believe that, in accounting for deep strictures, the possible influence of spasm as an exciting cause does not as frequently obtain as is claimed. My personal observations and experience have led me to think differently. The reflex character of such deep strictures is not so often recognized as its importance and frequent influence demand.

The two following cases will afford good examples of the subject under discussion :

CASE I.—Julius A., aged 24; single. Has had repeated attacks of gonorrhœa, the last occurring about six months ago (October, 1885). At the time the patient was seen, there was some slight urethral discharge. Complained of pain on urination along the urethra and especially at the end of the penis. Passes a very small stream of water, with some effort at times.

Upon examination, the circumference of the penis measured three and one-half inches. The calibre of the urethra should therefore be 34 F. to represent the normal proportionate relation as advised by Dr. Otis. At an inch and a half from the meatus there was a stricture of 14 F. and one also at three inches of 10 F. The meatus itself was 24 F. In the deep urethra a stricture was discovered which resisted the passage of a filiform bougie. It was thought that the deep stricture was of reflex origin. Dr. Otis, who was invited to see the case, was of the same opinion, and advised the division of the anterior strictures with the meatus to 34 F., which was performed. The operation confirmed the diagnosis concerning the deep stricture, as a 34 F. sound was readily passed into the bladder. The patient convalesced rapidly and satisfactorily.

CASE II.—Frank R., aged 26, single. Has had several attacks of gonorrhœa. After the last attack he experienced some pain on micturition, especially over the suprapubic region and at the extremity of the penis. Sometimes he had difficulty in passing water, being obliged to make an expulsive effort to do so, and afterwards for a little while the urine would dribble away. He had found it impossible sometimes to urinate at the time he felt the inclination to do so, but never had retention, so that instrumentation became a necessary resort for relief. Has been suffering from a gleet discharge for a long while, and when he urinates the water flows out in several streams.

An examination revealed a contracted meatus urinarius. The circumference of the penis measured three and one-quarter inches which would indicate a urethral calibre of 32 F. A stricture of 14 F. was discerned at three and one-half inches by Otis urethrometer and a filiform stricture in the deep urethra was also discovered. As in the preceding case, the deep stricture was thought to be spasmodic, and in accordance with Dr. Otis' advice, who also examined this patient, the meatus was enlarged to 32 F., and with the dilating urethrotome the contraction at three and one-half inches incised to correspond with the normal urethral calibre of 32 F. After the operation a 32 F. sound was passed without obstruction into the bladder, although a filiform bougie was arrested prior to the operation.

These two cases, among a number of others in the experience of surgeons, afford important examples of the fact that deep strictures are sometimes entirely dependent upon contractions in the anterior urethra and indicate the expediency of first removing the anterior obstructions before resorting to the more serious operation of external urethrotomy.

I have thought that a deep stricture, when spasmodic, imparted a peculiar, elastic resistance to the expert touch when an instrument was

carefully pressed against it, which would tend to characterize the nature of such strictures, but, after all, the surest way of corroborating the diagnosis would be an operative procedure, respecting the anterior contractions, when any exist, and afterwards carefully attempting to pass a full-sized sound. Unless the stricture tissue has been thoroughly divided, the spasm will not be wholly relieved, therefore due caution, to render the operation successful as to results, is advised by attention to the importance of a complete division of the anterior contractions.

One of the above patients (Case II.) had two severe hemorrhages following the operation—one the second day and the other the third day after, but they were readily controlled by the introduction and retention of an endoscopic urethral tube aided by pressure upon the perineal portion of the urethra. The urethral tube was worn for three days without causing any irritation worthy of notice.

It is said that an important diagnostic feature of spasmodic stricture would be the suddenness of its appearance or the possibility of passing urine at some time previous to the attack during the previous twenty-four or thirty-six hours. I cannot agree with these views entirely, for I have seen patients suffering from organic strictures with the same experiences above noted. It may be, however, as stated by Rynd, that “when there is complete retention of urine, and the patient applies, writhing and straining with painful and continued efforts to discharge the contents of the bladder and not a drop appears, the presumption is that he is suffering at present from spasm, no matter what his other troubles may be.” In other words, spasm is almost always an element present, or likely to be present, when there is a contracted meatus or a stricture of any calibre along the pendulous urethra. Sometimes spasm is relieved by a warm sitz-bath, followed by a full dose of opium. The patient may be etherized and an attempt be made to pass a catheter if the symptoms are urgent. Should instrumentation be determined upon, I would advise the injection of a four-per-cent solution of cocaine before passing the catheter, as the pressure of an instrument in the urethra may irritate the mucous membrane and aggravate the spasmodic condition to such a degree as to baffle the most skilful operator in its introduction. The sedative effect of cocaine in such emergencies is very positive, whether the spasm be due to irritation reflected by anterior pathological conditions or is purely idiopathic.

I have seen the good effects of its use in both conditions, when attempting to use the catheter or pass sounds for diagnostic purposes. The use of this solution, however, with the ordinary relief which the patient may experience from this treatment can be only palliative and of temporary duration, when an organic stricture complicates the condition of spasm. The only means of permanent relief must be the removal of the

organic lesions, which should be done without hesitation when all other means of relief are without avail, and before the extreme measure of puncturing the bladder is resorted to.

941 MADISON AVENUE.

THE VALUE OF LANOLIN.¹

BY

GEORGE HENRY FOX, A.M., M.D.

LANOLIN is a fatty substance extracted from the wool of sheep, and recently brought to the notice of the profession in Germany by Liebreich, of Berlin. In an interesting paper, he has discussed the chemical composition of the substance, and pointed out its theoretical virtues. Lassar has followed with a paper in which he reports cases of skin disease, in which he claims that lanolin, as a basis of ointments, has proved itself to be of practical value. A large supply has now reached our market, and we are already beginning to hear from those whose motto would seem to be, *De novis nil nisi bonum*.

According to Liebreich, lanolin is a peculiar substance in which the fatty acids are found in combination with cholesterin, instead of glycerin, as is the case with the fats and oils in ordinary use. It is to be found in the hair or wool, the horns and the hoofs of certain animals, and in the feathers of birds. It appears to be the natural fat of the keratinic tissues. As it is now found in the market, it contains about twenty-five per cent of water, after evaporation of which it becomes stiffer and darker. It is soluble in equal parts of ether, and in two parts of chloroform. It emulsifies with alkalies, mixes readily with lard, oil, or vaseline, and serves as a good basis for ointments, inasmuch as powders rubbed up with it become quickly and finely subdivided. It is strictly neutral in reaction, and is not liable to become rancid.

That it is absorbed by the skin more readily than either lard or vaseline has been claimed for it, and is shown to be a fact by the following experiment, which was made at the Skin and Cancer Hospital under the supervision of the House Physician, Dr. H. W. Blanc.

Upon the anterior surface of the forearms of a young girl, spaces were marked off, four by six inches in extent. Upon the space marked on the right forearm, fifteen grains of lard were rubbed for fifteen minutes. The left forearm was treated with lanolin in the same manner. The lard was softened more quickly by the heat of the skin, and was

¹ Read at the New York Academy of Medicine, Section on Therapeutics, April 21, 1886.

spread much more readily over the surface. With as nearly an equal amount of pressure as it was possible to give, the lanolin was found to redden the skin more readily than the lard. At the expiration of the fifteen minutes, the greasy matter remaining upon each forearm was carefully collected by means of a spatula, and weighed, with the following result:

Weight of lanolin used.....	15 grains.
“ “ “ removed from skin.....	5 “
“ “ “ absorbed.....	10 “
Weight of lard used.....	15 grains.
“ “ “ removed from skin.....	10 “
“ “ “ absorbed.....	5 “

We see, therefore, that while two-thirds of the lanolin disappeared during the rubbing, only one-third of the lard was lost.

To test the comparative rapidity of absorption of lard and vaseline, similar spaces were marked off upon the back of a young man upon either side of the spine and beneath the scapulæ. Fifteen grains of each were rubbed in for fifteen minutes, and the amount scraped off was weighed as before, and with the following result:

Weight of lard used.....	15 grains.
“ “ “ removed from skin.....	8 $\frac{1}{4}$ “
“ “ “ absorbed	6 $\frac{1}{4}$ “
Weight of vaseline used.....	15 grains.
“ “ “ removed from skin	9 $\frac{1}{2}$ “
“ “ “ absorbed.....	5 $\frac{1}{2}$ “

We note in this experiment that the lard was more readily absorbed than the vaseline, although the difference was not as marked as in the case in which the lard and lanolin were tested.

As a proof of the rapid absorption of drugs by means of lanolin frictions, Liebreich states that a solution of bichloride of mercury in lanolin, of a strength of 1 : 1000, will produce a metallic taste in the mouth, after being rubbed into the skin. I have rubbed repeatedly upon my own skin, as well as upon others, a lanolin ointment of ten times this strength, and failed to get any gustatory proof of its absorption. In some subjects of my experimentation, however, the peculiar metallic taste in the mouth has been noted, but it is possible that a similar effect might have followed the use of lard or even vaseline. As an improvement in our present method of endermic medication, particularly in the

inunction cure of syphilis, lanolin may prove to be of great value, but time will be required to settle this point.

Without discussing further the theoretical use of lanolin, let us consider the question as to its practical value when tested in the treatment of skin diseases. Since the first importation of lanolin from Germany to this city by F. Bagoë & Co., I have been using it in nearly all cases in which I have had occasion to prescribe an ointment, and I must confess that I have failed to see any remarkably beneficial effects from its use. On the contrary, it has proved objectionable in some instances on account of its color and consistence, and in certain cases of acute inflammatory disease of the skin it has not been found to be as bland as I had been led to expect. When I have used a lanolin ointment upon one side of the body, and a lard or vaseline ointment upon the opposite side, the patient has usually expressed a preference for the latter, and in no case has the rapid absorption of the former been so marked as to attract notice.

In conclusion, my views respecting lanolin may be summed up in the following statements:

1. Lanolin is more readily absorbed by the skin than any other fatty substance.

2. As a basis for ointments, it is useful when an effect upon the deeper skin or upon the whole system is desired.

3. On account of its firm consistency, it is advisable to mix with it a certain amount of lard, especially in cold weather.

4. When applied to a highly inflamed skin, lanolin may not prove as bland as *fresh* lard or *pure* vaseline.

5. Considering its recent introduction, its questionable superiority, and its present cost, it cannot be recommended as yet as the best basis for all ointments.

DERMATOSES OF THE EYE.

BY

CHAS. W. ALLEN, M.D.,

Surgeon to Charity Hospital.

THAT skin diseases should extend at times to the eyelids from adjacent parts is quite natural. It is also easy of comprehension that an eruption of the general cutaneous surface should appear as well on the external or skin surface of the lids, but that eruptions, which we consider as belonging to the skin proper, should occur upon the globe of the eye would seem to require an explanation. A lupus of the eye-

lid may extend to the conjunctivæ, and subsequently attack the cornea; but, as a rule, the successive steps in the process may be watched. So, too, an epithelioma, which first appears as a harmless-looking tumor of the lid, may destroy tissue after tissue until lid, muscle, globe, all are gone, and a hideous cavity alone remains.

When, however, vesicles (as in herpes zoster) or pustules (as in variola) or tumors containing skin elements make their appearance upon the eyeball, we must look deeper than the surface for an exciting cause.

It has appeared to me that those diseases of the eye and its appendages in which occur lesions usually found upon the cutaneous surface, and those skin diseases having an especial predilection for the region of the eye might properly be termed *dermatoses of the eye*, and I have collected under this heading a few recent observations.

DERMOÏDE OR HAIRY NÆVUS OF THE CONJUNCTIVA.

Dr. Ficano (*Annali di Ottalmologia*, XIII., fasc. VI.) has recently had under his observation a young girl who presented herself with several hairs growing from the surface of the left globe. They had been first noticed three months before. Contrary to the statements generally made in works on the eye, the tumor was not at the free border of the cornea, but almost a centimetre distant from it, and the hairs were not downy, but quite long and large.

The site of the tumor was at the upper and outer part of the globe, where quite a large area of hypertrophy of the conjunctiva was noticeable.

Twelve hairs were counted growing from the surface of the tumor. They were the color of the girl's hair, but somewhat finer. All the members of the family had abundant hairy nævi on various regions of the body.

Dermoïdes or dermoid tumors of the eye are comparatively rare, as a reference to the reports of eye infirmaries has convinced me. Single and collected cases are, however, to be found scattered through ophthalmological literature, and Graefe, Arlt, von Wecker, and many others have contributed to a knowledge of the subject.

These dermoid tumors are of a yellowish-gray color usually, varying in size from a lentil to that of an olive, situated upon the globe, as a rule, at the sclero-corneal limbus. At about the time of puberty, they become covered with hairs, which may attain a considerable growth. They are not likely to be mistaken for other growths, such as lipoma, sarcoma, or cystic tumor of the conjunctiva, the latter being translucent and having a more rounded form. When excised and examined microscopically, they are found to contain all or many of the elements of the skin. In addition to the hairs and hair-follicles, papillæ, epidermis, sebaceous and sweat glands have been noted.

Various theories have been put forward to account for this exceedingly interesting deformity, but as yet no one, I believe, has been generally accepted. As early as 1838, Prof. Ryba claimed that they were caused by an arrest of development in the eyelids during embryonic life, the ectoderm not being transformed into the conjunctiva until entirely covered by the lids; the arrest of development preventing this transformation at a point resulting in the formation of the dermoid tumor.

PATHOGENY OF DERMOÏDES OF THE EYE.

Tillaux gives, in the *Union Médical*, July 30, 1885, a very plausible explanation of the existence of dermoïdes of the eye, based on a study of embryogeny.

In the very commencement of embryonic life, at about the fourth week, the tegument which passes in front of the primitive ocular vesicle thickens at the point where the cornea afterward appears. This thickened portion becomes depressed in the centre or umbilicated. Soon a pouch is seen to form, which communicates by a very narrow opening with the cutaneous surface; the protuberant part of this pouch passes backward into the primitive ocular vesicle, which is depressed at this level. The epidermic layer thus invaginated produces the lens, while the dermic layer forms the capsulo-pupillary membrane or capsule of the lens. Now, at a given moment, there exists between the lens and the surface of the eye a cutaneous pedicle which soon ruptures and disappears. Now let us suppose that a portion of this pedicle persists at the time of formation of the cornea and sclerotic. can we not easily understand the subsequent apparition of a tumor having all the characteristics of the skin? Based on this embryonic study, the author believes that dermoïdes are formed from the remnant of the embryonic cutaneous layer which persists after the formation of the lens and the vitreous, and becomes imprisoned in the thickness of the external membrane of the eye.

ANOTHER THEORY.

Two years ago, Van Huise published an article on the complication of these dermoid tumors, in which he explains their formation in a different way.

He attributes them to the amnion becoming adherent to the globe of the eye during foetal life.

Coloboma of the lids, fissures and wrinkles of the skin are frequently found co-existing with the disease. All of these Van Huise attributes to the same cause, and believes that the dermoïdes cause the coloboma by becoming interposed between the parts which go to form the eyelids. Dr. Larbouret (*Thèse de Paris*, 1885) holds much the same view, believing that amniotic adhesions prevent the complete development of the lids, and give rise to invaginations of the primitive palpebral layer upon

the globe. Dr. Pollak records a case in the *American Journal of Ophthalmology*, December, 1885, and refers to one recorded by Dr. Taliaferro in the *American Journal of Medical Sciences*, 1841, in which he had successfully excised a congenital dermoid tumor from each eye of a fifteen-year-old girl.

Prof. Masse, of Bordeaux, has just published a work on cysts, pearly tumors, and dermoid tumors of the iris, in which he states his belief that the dermoïdes originate by cutaneous inclusion occurring in some way as the result of a disturbance of development, and that they may remain inert until some traumatism occurs to give an impulse to the proliferation.

PEMPHIGUS OF THE CONJUNCTIVA.

Under this title, Dr. Bæumler has published several cases (*Klinische Monatsblätter für Augenheilkunde*, August, 1885) in which a parenchymatous xerophthalmia had developed with its complications of ectropion, cicatricial degeneration and deformity of the lids, and infiltration and ulceration of the cornea. The eruptions of pemphigus had been observed during the disease on the body, and also upon the eyelids.

Various authors have mentioned such complications (Alibert, Cooper, Hardy, Wecker). Dr. Boucher (*Recueil d'Ophthalm.*, October, 1885) objects to the name "pemphigus of the conjunctiva," and says that the disease is the last step in an inflammatory process, resulting, as Weber, Cohn, and others have shown, from widely diverse causes, among which are cutaneous affections which have extended to the eye.

Mr. Lang read a paper on this same subject at the London Ophthalmological Society, Nov. 12, 1885. He described two cases, both occurring in women.

In one case blisters had appeared on the backs of the hands and front of the body in 1876, since which time she had never been free from the eruption. A vigorous shake of the hand would produce a blister. The palms and fingers were smooth, thickened, and contracted, and the toes were in the same condition. At the same time that these changes in the skin began, the eyelashes turned in and the whites of the eyes became red.

In the other case, the right palpebral fissure was much shorter and narrower than normal, both lids being completely adherent to the globe. The conjunctiva was replaced by a dry, black, opaque membrane.

ZONA OPHTHALMICA.

The monograph of Hybord (*Thèse de Paris*, 1872) on zona has become classic, although the disease had been previously described by Hutchinson, Bowman, Arlt and others.

Two forms of the disease are encountered: one benign, the other severe.

The first is never accompanied by affections of the eye; the second does produce alterations of this organ.

According to Besnier (*Journal de Méd. et de Chirurg.*), the difference in the two forms of the disease depends upon the severity of the lesion of the Gasserion ganglion, which is proper to zona, and upon the localization of the disease on the various branches of the trigeminus.

So long as the ethmoidal nasal branches are not involved, we have to deal with the benign form. The disease becomes severe if the nasal cavity and the eye are attacked.

To be able to predict that the cornea will be involved, and to prevent it, frequent examination should be made of the sensibility of the cornea, and of the appearance of the eye, in every case of zona of the face.

An œdematous redness of the conjunctiva and the appearance of small vesicles on the cornea or sclerotic is usually noticed in the severe form. The iris may be altered, small ulcerations may replace the vesicles, and in rare cases there may be facial paralysis by propagation.

The treatment of zona is unsatisfactory, being mainly directed toward the symptoms. External medication consists in the application of hot emollient fomentations, inunction of glycerole of starch and extract of belladonna, wet compresses to the eye, and instillations of atropine sufficient to keep the pupil dilated.

The pain may persist long after the eruption has disappeared, especially in elderly persons.

TUMORS OF THE EYELIDS—MELANOTIC SARCOMA.

A case of this rare disease was observed at the clinic of Dr. Bruno, in Turin (*Gaz. delle Cliniche*, 1884, No. 35). The subject was a woman of sixty-six years, who had never had any serious disease. A small, black, pediculated tumor first appeared at the middle of the ciliary border of the right upper lid. This was removed by a ligature, but a month and a half later another formed, and within fifteen months reached the size of a hazelnut. It was now completely excised. Microscopical examination showed an infiltration of young connective-tissue cells in the skin and orbicular muscle. The tumor itself was made up of small and large round cells and fusiform cells, the latter being in greatest abundance. The pigment was disposed in round heaps, and also in granulations, occupying in part the interior of the cells.

The stroma was formed of connective tissue with small spaces. The nucleus, as is often the case in pigmentary sarcoma, was free from pigment.

Dr. Gallenga refers to the extreme rarity of these tumors, having found two publications only on the subject, one being by Gibson, the other by Horner.

(To be continued.)

PEMPHIGUS FOLLOWED BY ALBUMINURIA.¹

BY

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West Troy, N. Y.

THE subject of this case was the mother of five children, four of whom are living and in good health. She was of Scotch descent. Her parents are both living, father at the age 83 years, and mother 81, and in good health. She had a clear, fair, white skin, was about five feet four inches tall, and in her usual health weighed 110 pounds.

In the year 1874, January 1, she gave birth to her third child, had an easy labor, and got along well till, the fifth day, she broke out on her hands and arms with watery blebs, or an eruption described under the name of pemphigus; another name given it is pompholyx. These blebs or bullæ were oval-shaped bladders varying in size from a split pea to a large walnut. Each bulla contained a semi-transparent fluid which soon became opaque, and after a few days dried up, leaving a small scab, or giving rise to an excoriated surface, but no scab. One crop followed another on the same surface, and sometimes spread over the whole leg or arm, and sometimes on the body.

After about four weeks of good tonic treatment she recovered, and remained in good health till after her next confinement, which occurred April 6, 1876, two years and three months from the previous confinement.

On the third day after, she again broke out, much more severely than the previous time; now it extended all over the hands, arms, feet, and legs, and also on the body. On the hands, feet, and legs, up to the knee, they were very thick, running into each other, forming a complete layer of watery blebs; so thick, that not a spot of sound skin could be seen between. They were very painful, the burning, smarting pain depriving her of sleep night and day.

After a tonic course of treatment of about three months, they went away, leaving her again in her accustomed health, which continued good till she again found herself *enceinte*. When about three months gone she broke out again, the eruption continued till about two months previous to her confinement, when it went away till after confinement, which occurred on the third day of November, 1879. She gave birth to a plump, healthy boy, with an easy labor; had got through when I arrived; got

¹ Read before the Union Medical Society in Troy, N. Y., April 6, 1886.

along well till, the third day, she broke out again, the eruption yielded to a tonic treatment in a few days, leaving her as well as usual.

The following pills were used in this case, which seemed to do more good than anything else.

R Quinine.....gr. i.
 Quevenne's Iron.....gr. i.
 Arsenious Acid.....gr. $\frac{1}{32}$.
 Dose. One three times a day.

May 10, 1885, I was again called to see the same patient, when she complained of being so weak and languid that she could hardly keep about. Since the previous visit narrated above she has lost her husband, now about two years ago, with consumption, and for the last two years she has had the care of her aged parents, as well as her own family.

I now find her with feet and ankles swollen, and evidently dropsical. An examination of her urine showed a large proportion of albumin; she looked care-worn, and weary.

I put her on a tonic and diuretic course, with as much Poland water as she could drink; but the dropsy continued, and she gradually lost her strength till she died, October 1, 1885.

Her mental faculties, also her eyesight, continued good till the last.

Post-mortem, twenty-four hours after death. Rigor mortis well marked. Body well nourished, skin very white. Stomach and liver, as well as the other organs, except the kidneys, were normal and seemed to be healthy. The kidneys were of the white variety, though not much enlarged, soft and smooth surface when cut across. Its investing membrane easily stripped off. The cortical substance had lost its red tint, and presents a pale appearance.

Watson says: The coarse anatomical characters of the kidneys in the two more chronic forms of Bright's disease are in striking contrast with each other. They differ remarkably in size and color, and are spoken of as the large white and small red kidney. The average weight of the adult human kidney is between four and five ounces. In Bright's disease, some have been met with weighing twelve ounces, others weighing scarcely two. The large white kidney is generally of soft consistence, and has a smooth surface, which is apt to become indented by linear depressions, and so to assume in its enlargement a lobular shape. Its proper investing membrane is easily stripped off.

The small contracted kidney, on the contrary, is hard and red; its surface is rough, as if strewed with prominent grains, and has sometimes a scarred appearance, and its outer membrane comes off with difficulty.

The cortical substance being the main seat of the morbid changes, the alteration of color is the most conspicuous in the cut surface of the

large kidney, which has lost its red tint and its orderly aspect, and presents a pale, nearly homogeneous appearance; not unlike, in some cases, the section of a parsnip. Its natural striæ are confused or obliterated. The incised surface gives one the notion of some deposit whereby the original texture of the part is obscured.

The blood-vessels, many or most of them, seem to have been emptied by compression, or to be blocked up by yellowish solid matters; while the healthier pink pyramidal masses belonging to the medullary portion of the kidney appear to be displaced or pushed aside, or encroached upon by the same yellowish matter, which sometimes interposes itself between and opens out their radiating tubules. Together with these changes of appearance, I have several times found the veins that emerge from the kidney firmly plugged up by coagula of blood.

LEUCODERMA OR VITILIGO.

BY

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THE subject of this article is Mrs. E., æt. 60; married. Her parents were both pure-blooded colored people. Mrs. E.'s grandfather was a native of Guiana; the maternal grandmother was a slave in the days of Washington. The ancestors of the patient, as well as most of her relatives, are very dark. She was married when quite young, and from this marriage have followed nine well-developed colored children. The disease in question first made its appearance in 1856 in the form of a white spot on the side of the right leg, which slowly spread, and in time was joined by similar spots on her breast and over the main parts of her body. About fifteen years ago, there came little rings of white about her finger nails, which gradually extended upwards, covering her hands and arms. In the mean time, the white upon her body crept up the back of her neck and over her scalp.

About a year ago, the color upon portions of her face began to give way, and two or three large macular areas are now to be seen. According to authorities on the subject, the disease, once developed, may continue for an indefinite period, or, after a time, come to a standstill, and remain in that condition for many years. Occasionally spontaneous recovery takes place, that is, the skin may recover its normal coloration. The disease affects the Caucasian as well as the negro, and probably the races of intermediate tint. It has never been met in childhood in the

white race, but it has been seen from early adult life to old age. It may be confounded with but a few others, such as partial albinism and certain phases of macular leprosy. In an analysis of eleven thousand cases of skin disease, Dr. McCall Anderson met with only four cases of vitiligo. The treatment of the disease in question is of necessity very unsatisfactory, although in the above case the use of faradism seemed for a time to retard its progress. In a paper read by Dr. R. Harvey Reed, of Mansfield, O., before the Ohio State Medical Society, on the subject of leucoderma, the following conclusions were formulated:

1. The disease is not confined to sex, and usually begins in adult life.
2. This affection may be confounded with morphœa, chloasma, tinea versicolor, lentigo, partial albinism, and certain phases of macular leprosy. The disease is quite easily differentiated from these maladies.
3. This disease is probably a nervous affection, and traceable to the great sympathetic system which produces an altered blood supply, and hence the perverted pigmentation of the derma.
4. Treatment is very unsatisfactory, although an apparent benefit may be derived from the use of electricity.

Dr. Duhring defines this cutaneous affection as an acquired disease, consisting of one or more sharply defined, rounded, irregularly shaped, variously sized and distributed, smooth, whitish spots, whose borders usually show an increase in the normal amount of pigment.

Prof. Piffard gives the following definition and description of the disease in question:

“Vitiligo is an affection characterized by a localized disappearance of the cutaneous pigment. It becomes noticeable by the development of one or more small pigmentless spots, the color of which varies from a dead-white to a faint rosy hue, the particular tint depending on the activity of the circulation in the affected part. The hair, if there be any on the spot, loses its color, and becomes white. Surrounding these pale patches, there is frequently a border characterized by increased pigmentary deposit, which gradually shades off into the hue of the normal surrounding skin. The appearance of one spot is usually followed by the development of others. The spots usually, for a time, increase in size, and unite with neighboring ones after forming an irregular patch of considerable extent. A considerable, and even the major part, of the surface may be thus invaded. With the exception of the loss of color, the affected portions do not present any other anomaly, but appear to preserve their various functions unaltered. The parts most frequently affected are, in my experience, the hands, face, neck, and genitals.”

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

163D REGULAR MEETING, APRIL 27, 1886.

DR. W. T. ALEXANDER, *President*.

DR. FOX showed a case of

MACULAR LEPROSY.

The patient, a Cuban, has had the present eruption for the past twelve years. The lesion exists chiefly on the trunk in the form of brownish pigmented spots, in which the tactile sensibility is lessened. The patient naturally has a rather large amount of hair scattered over the body, but where the patches are there is an entire absence of hair. There is mottling of both arms and considerable scaling of the elbows. The face and other portions of the body present a bronzed appearance, and there is a commencing leonine aspect of the face. There is also considerable adenoma present.

DR. SHERWELL said that the case appeared to him to be one of macular leprosy, but he would prefer suspending judgment until he could examine the patient more carefully by day-light.

DR. ALLEN had never seen a simple case of macular leprosy, but had observed macular lesions in connection with other forms of the disease.

DR. FOX said that it was impossible to make a diagnosis except by day-light, and while he was not absolutely positive as to the nature of the disease, he did not see what else it could be. He made his diagnosis from the fact that the disease was endemic where the patient lived, the brownish appearance of the macules, their annular form with a tendency to fade in the centre, the marked anæsthesia of the spots, as well as the swelling above the eyes, and the bronzed appearance of the skin.

DR. MORROW presented a case of

PITYRIASIS RUBRA, WITH VESICULAR LESIONS.

The patient, æt. 37, a compositor by occupation, had been admitted to the dermatological ward in Charity Hospital, April 27. The case was presented not only on account of the comparative rarity of this affection, but principally on account of the presence of certain eruptive elements not usually seen in pityriasis rubra.

The patient was a hard drinker, had never had any venereal trouble; his father was scrofulous; all the other members of his family healthy. He had various attacks of skin trouble for the past twelve years, but had been comparatively free from any eruption for a period of nearly three years past. Three months ago, the present eruption began as small, red patches, somewhat scaly, which gradually grew larger and ran together, until now the entire surface of the body is occupied by the eruption, which is everywhere confluent, except upon the dorsal surfaces of hands and wrists, and below the knees, where it exists in the form of rounded reddish patches. Twice before, according to the patient's statement, the eruption had been generalized, but the scaling was not so extensive as at present. The characteristic features of pityriasis rubra are admirably shown in this case, the abundant exfoliation of dry, papery scales, which are

easily separated from their attachment, and flake off in very thin lamellæ, showing beneath a red, dry, non-infiltrated shining skin. The peculiar interest of the case, however, consists in the presence of innumerable pin-head-sized vesicles, or vesico-pustules, with which the palms and soles [are thickly studded, showing beneath the thickened epidermis of these regions as opaque or yellowish points. In the central portions of the palms they have become confluent, completely detaching the epidermis from its subjacent connections. There is also seen a circle of closely set, minute pustules completely surrounding the reddish patches upon



the dorsal surfaces of the hands, wrists, and the lower extremities. These vesicles are developed in the extreme peripheral margin of the patches, and are, according to my observation, altogether unique.

DR. FOX said that he had never seen a case of pityriasis rubra where vesico-pustules were present, or where there was the condition seen on the legs. The upper part of the body certainly presented the characteristic appearances of pityriasis rubra. It would be well to consider whether two distinct diseases might not be present.

DR. ALLEN would make the diagnosis of pityriasis rubra, but believed that some other condition was associated with it.

DR. SHERWELL believed that it was a pityriasis rubra, or pemphigus foliaceus, and if it were the former, it was an uncommon form.

DR. MORROW said that he had shown the case because of the vesico-pustular element present, which all would recognize as entirely foreign to the classical features of pityriasis rubra. When he first saw the patient's hands, before looking at the remainder of the body, he thought it might possibly be a pemphigus foliaceus, but on close questioning he found that there had been no bullæ, nor had there been any moisture at any stage of the disease. He believed that the condition on the limbs did not exclude the diagnosis of pityriasis rubra. In previous attacks, the lesion commenced in small red spots, running together and forming large patches. He (Dr. Morrow) said that many authorities recognized a certain relationship existing between pityriasis rubra and pemphigus foliaceus; it was not surprising, therefore, that they might have an exudative element in common. He had never seen a more typical case of pityriasis rubra as far as the body was concerned, there being no thickening of the skin and abundant scaling, the scales being made up of thin lamellæ.

DR. FOX asked Dr. MORROW if he had ever seen or read of a vesicular eruption in connection with pityriasis rubra.

DR. MORROW said that he could not recall a similar case in his own experience, but he believed that an exudative element might be present in pityriasis rubra, and yet be so slight as to escape observation. He recognized the fact that any chronic skin disease might be modified in its typical features, and, also, that accidental eruptive elements might be superadded, either from local or constitutional causes. In this case, for example, the added phenomena may have been determined by chronic alcoholism.

DR. SHERWELL had had at least half a dozen cases of pityriasis rubra, but never saw one where the scales were so tremendously large. He often had examined the urine, but had not found albumin; there was an abundance of urates.

DR. TAYLOR spoke of a case of pityriasis rubra, which he saw with Dr. Zinsser, in whom the urine was examined, and sugar found. He had examined the urine in other cases of pityriasis rubra, and found sugar which disappeared after the involution of the disease. He asked Dr. Sherwell if he had ever examined the urine for sugar in such cases.

DR. SHERWELL said that he had examined only one case, and in that one no sugar was found.

DR. MORROW thought that it would be interesting from a pathogenetic point of view to inquire whether there was any relationship between this chronic form of disease and the acute dermatitis exfoliativa produced by the ingestion of certain drugs. Many of the drug exanthems are often followed by more or less extensive desquamation. He had seen a case where the epidermis had exfoliated in large flakes from the surface, and had been stripped from the fingers like a glove.

DR. MORROW afterward showed a case of

ARSENICAL ERUPTION.

The patient, a boy, aged 11, had been sent to him a few days ago by Dr. Gottheil, of the New York Polyclinic, for an opinion as to whether the eruption was an arsenical dermatitis. In the latter part of February the child was suffering with chorea, and was put upon arsenical treatment, commencing with five drops of Fowler's solution, and increasing to sixteen drops three times a day; it was decreased in quantity, because it caused conjunctival and gastric disturbances, with puffiness of eyelids and swelling of the ankles and feet. Some time in March an eruption developed on the body and extremities, which, according to the mother's statement, always became intensified when the doses of the arsenic were increased, and began to disappear when the arsenic was temporarily discontinued. The lesion was erythemato-papular, the spots running together and forming patches. It presented many of the appearances of a rubeolous eruption, and was extremely itchy. The skin was rough, and in some places desquamating; there was a grayish-brown, almost black, discoloration of the surface, especially marked over the abdomen and inner surface of the thighs. The dorsal surfaces of hands were occupied by a coating of a greenish color, cracked and fissured, resembling ichthyosis. The tongue was pale and flabby. The discoloration was evidently pigmentary, and could not be removed by friction with soap.

DR. KEYES saw no reason why it was not an arsenical eruption. In one case of rebellious psoriasis to whom he gave large doses of arsenic, an extensive papular eruption made its appearance on the neck and body, accompanied by intense pruritus; the eyes were swollen, and the tongue red. Exfoliation of the skin followed, disappearing when the administration of the arsenic was stopped.

DR. GOTTHEIL, by invitation, said that when he first saw the case, three weeks ago, the eruption was more decided, and the flexures of the joints were markedly inflamed. The backs of the hands were covered with an eruption of large papules, which gave place to the peculiar scaly coating now present. He asked if the pigmentation of the surface was due to the administration of arsenic.

DR. MORROW replied that a grayish or dark-brown pigmentation was one of the most characteristic features of the prolonged use of arsenic. Its occurrence was mentioned by many authors. Bazin had compared it to a staining of the skin by nitrate of silver. It was a question whether the discoloration was due to a chemical combination or an abnormal deposition of pigment. The discoloration was generally brownish, and in this case a peculiar feature was that it was greenish upon the hands, and almost black upon the abdomen and thighs.

DR. FOX thought the greenish discoloration was secondary and due to the dirty condition of the skin.

DR. MORROW said that the acute erythemato-papular eruption was the most common form of arsenical dermatitis, although almost every variety of eruptive disorder had been observed to follow the ingestion of the drug.

DR. FOX read a paper on

THE VALUE OF ARSENIC IN SKIN DISEASES,

which may be summed up as follows: The very common practice of giving arsenic in nearly every case of skin disease is irrational and harmful.

It is irrational, because in the majority of cases the remedy produces very little, if any, benefit.

It is harmful for the following reasons:

a. In many cases it increases cutaneous congestion, intensifies pruritus, and thereby aggravates the eruption.

b. It is very frequently relied upon to the exclusion of other and better plans of treatment.

The universal employment of arsenic in the treatment of skin diseases is no more a proof of its value than was the former practice of venesection for most diseases a valid argument in favor of that plan of treatment.

The beneficial change which sometimes follows the use of arsenic is frequently due to adjuvant treatment, and erroneously attributed to the administration of this drug.

In spite of the wide-spread belief in the value of arsenic, there has never been published a series of carefully recorded cases in which the sole administration of this drug has produced any notable therapeutic results.

There are some forms of chronic inflammatory skin disease, and possibly some affections of a malignant type, in which the internal use of arsenic will undoubtedly exert a beneficial influence.

In most cases of inflammatory skin disease, regulation of the diet, and such hygienic and medicinal treatment as tends to improve the general health of the patient will do infinitely more good than the routine administration of arsenic.

GANGRENE CAUSED BY IODINE-COLLODION.--The application of iodine-collodion to a frost-bitten finger in Vienna last year, it will be remembered, led to a loss of the finger and the suicide of the physician from mortification on account of the unfortunate notoriety given the case. Dr. Vogelsang, of Biel, now reports (*Memorabilia, Med.-Chir. Rundschau*) a case in which iodine-collodion painted over a large surface was followed by gangrene of the skin and sloughing. In one case collodion was applied over a gland which had been painted with iodine; the result was a slough and an ugly ulcer.--*Med. Times*, April 3, 1880.

Correspondence.

THE TREATMENT OF RHUS-POISONING.

CHARLESTON, W. VA., April 26, 1886.

Prince A. Morrow, M.D.

MY DEAR DOCTOR:—Will you please give us in the next number of your JOURNAL OF CUTANEOUS AND VENEREAL DISEASES a reliable remedy or remedies for poison oak or rhus toxicodendron? We have a great many cases here, and especially at this time of year.

I have as yet seen nothing worth mentioning in the books or journals that would do more good than cream or vaseline. If we have a safe, efficient, and reliable remedy, will you please give us the benefit of it?

Yours respectfully and fraternally,

WM. W. TOMPKINS,

Sec'y of the Medical and Surgical Society of the Kanawha Valley.

In undertaking the task of giving our correspondent a "reliable remedy" for the treatment of rhus-poisoning, the editor of the JOURNAL finds himself confronted with an embarrassment of riches. Medical literature abounds in recipes which have been from time to time recommended as possessing specific virtues in the treatment of this distressing affection; but, however valuable they may have proven in isolated cases, their claims to infallibility have, unfortunately, not been confirmed when submitted to the test of extended clinical experience. It is well at the outset to recognize the fact that *there is no specific for the cure of dermatitis venenata*. It is to be treated on the same general principles as are indicated in the treatment of other inflammations of the skin directly provoked by external irritating agencies. The inflammation is self-limited, with a tendency to spontaneous recovery, and the principles of rational treatment are to relieve the subjective sensations of burning and itching, to modify the inflammatory action, and to prevent the extension of the eruption.

It is well known that the eruption first develops upon parts brought in direct contact with the leaves of the plant, or exposed to their emanations, as the hands and face. The poisonous principle of the rhus resides in a volatile acid termed *toxico-dendric acid*. It is still a moot point whether the extension of the inflammation to other parts of the body is a systemic effect, consecutive to absorption of the poisonous principle, or whether it is due to a direct inoculation of the parts by the nails, as in scratching. The latter view is, I think, the most probable; certainly, clinical experience conclusively proves the auto-inoculability of the eruption.

With a view of circumscribing the spread of the eruption, the patient should be cautioned against bringing the hands in contact with other parts of the body; especially should he be enjoined against handling the genital parts, as the integument of this region is peculiarly susceptible to the irritant action of the rhus. It is a matter of common observation that the genital parts of the male are much more frequently the seat of the eruption than the corresponding region in the female, and the explanation is found in the direct transfer of the irritating agent by the fingers in handling the parts during the act of micturition, in dressing, etc.

The treatment of the acute stage of the eruption should be essentially soothing

and protective. For this purpose, dusting powders and sedative or mildly astringent lotions should be used.

A lotion which I am in the habit of employing with good results is the following :

℞ Sodii hyposulphitis. ʒ i.
Glycerinæ ʒ ss.
Aq. ad ʒ viij.

M.

Apply with compresses dipped in the solution and frequently renewed. I have also used a strong solution of the sulphite of sodium with marked benefit. Two years ago, I treated several cases by simply painting the affected surfaces, every two or three hours, with sweet spirits of nitre. It seemed to have a very favorable effect in relieving the cutaneous congestion, besides imparting, as one of the patients expressed it, a "cooling sensation" to the surface. In cases where the continuous application of a lotion is impracticable, freely dusting the surface with an absorbent powder is to be recommended. I am in the habit of using Pears' Fuller's Earth, which is perfectly bland and unirritating, or the following combination :

℞ Pulv. Zinci oxidi. ʒ ij.
" Bismuthi subnitratis. ʒ i.
" Amyli ʒ v.

M.

It is important that the affected surface should be kept copiously covered with the powder ; an occasional sprinkling does little good. If there is much burning heat present, a little powdered camphor (ʒ ss. to the ʒ i.) may be added.

When the more acute eruptive features have begun to subside, a mild, soothing ointment should be employed. For this purpose, I know of nothing better or more universally applicable than the ordinary benzoated zinc ointment. Another very excellent dressing in this stage of the disease is the Lassar paste :

℞ Pulv. Zinci ox.,
" Amyli. āā ʒ ij.
Vaselini ʒ iv.

M.

It is not claimed that the plan of treatment outlined above is in any sense specific. The writer has employed it, modified, of course, to meet indications in particular cases, in a large number of cases, with the effect of relieving distressing symptoms, and materially hastening recovery. The good effects of the same treatment will be found to vary in different patients. There is a great difference in the susceptibility of different individuals to the irritant action of the rhus poison, and the difference in susceptibility is perhaps equally marked in relation to the influence of medication.

Two cases of rhus-poisoning came under my observation last summer, both members of the same family ; in both, the initial features of the eruption were equally severe, both were submitted to the same treatment ; in one case it was promptly effectual, in the other the inflammatory symptoms continued, with scarcely any abatement, for several days.

Should the editor's treatment not fulfil the conditions demanded by our correspondent, he need not be discouraged, especially if he believes that in a multitude of remedies there is safety. It is not possible to here enumerate the entire list of remedies which have been recommended in the treatment of rhus-poison-

ing, for their name is legion. To give only a few which are claimed to possess a remarkable efficacy in subduing the symptoms: lime-water; alum curd; a saturated solution of bicarbonate of sodium; a strong solution of chlorate of potassium; a solution of sulphate of zinc ($\frac{3}{4}$ ss. to the pint); a solution of carbolic acid (grs. ij.-iv. to the $\frac{3}{4}$ i.); a weak solution of sulphate of copper; dilute lead-water, etc. Compresses to be wet with these lotions, and applied every hour or two through the day. Dr. White, of Boston, and others, highly praise the efficacy of the ordinary black wash. Dr. Brown, U. S. N., claims that bromine (ten to twenty drops to the ounce of olive-oil or cosmoline) is a specific.

To turn now to the vegetable materia medica: a decoction of white-oak bark; a decoction of the bark or leaves of the elder; an infusion of the sweet fern; the tincture or fluid extract of serpentaria, lobelia, sanguinaria; infusion of the bark of the red sassafras, with sassafras tea, *ad libitum*, internally, have all been highly spoken of. Probably the most efficient of the vegetable remedies is the grindelia robusta, which may be used in the form of the fluid extract, diluted in ten to thirty parts of water.

Dr. Hyde speaks enthusiastically of an ointment made by incorporating a decoction of the inner bark of the American spicebush (*Benzoin odoriferus*) with cold cream. Dr. Edson highly extols the virtues of gelsemium in the treatment of rhus-poisoning (*Medical Record*, vol. xxii., p. 120). His formula is: \mathcal{R} Acidi carbolic, $\frac{3}{4}$ ss.; Fl. ext. Gelsemii, $\frac{3}{4}$ ij.; Glycerini, $\frac{3}{4}$ ss.; Aq., ad $\frac{3}{4}$ iv. M. Cloths to be moistened with this lotion, and applied to the affected parts. This, he claims, with the internal administration of the fluid extract of gelsemium every three hours, effectually relieves the burning and itching, and the eruption speedily disappears.

EDITOR OF THE C. AND V. JOURNAL.

DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

Purpura.

A PAPER by Dr. Bristowe, entitled "Clinical Remarks on Purpura Urticans, with Cases" (*Medical Times and Gazette*, May 9, p. 599), is of considerable interest. Two cases are narrated, occurring in boys aged 15 and 10 respectively, which bear a close resemblance to each other; in both there was abdominal pain and melæna, with persistent renal hæmaturia; and in both there was, from beginning to end, a recurrent purpuric urticarial eruption, affecting mainly the extremities. There was slight tendency to bleeding from other parts, as shown by spongy gums and epistaxis, and both patients became very weak and ill, although it did not appear that much blood had been lost, and, lastly, ordinary petechiæ, vibices, and ecchymoses, did not occur in either. Dr. Bristowe remarks that this combination of symptoms can hardly have been accidental, and does not accord with what is observed in ordinary purpura; the hæmorrhages, especially, occurred in connection with wheal-like tubercles of short duration. They began with the development of these tubercles, and ceased with their subsidence, the effused or accumulated blood then undergoing gradual removal by absorption. They never presented the deep violet tint and definite margins which usually characterize the petechiæ of purpura. They were always of a more or less vivid red, somewhat spotty in appearance, and, indeed, gave the impression not so much of a limited abundant extravasation, as of either permanent stagnation of blood in dilated capillary vessels, or groups of punctiform extravasations. Both cases got well while under arsenical treatment. A "case of rheumatic purpura" is reported in the same number of this journal (p.

60S) by Dr. Sadler, and is of interest, as doubt has been recently thrown by Immerman (in Ziemssen's "Cyclopædia") on the existence of purpura as a phase of rheumatism. In Dr. Sadler's case, though the fever was not very high (100° to 101° F.), and though the articular pains followed the rash, every symptom of acute rheumatism was represented; articular swelling, sweating, periosteal nodes, and endocarditis. There was no hæmaturia. A case of "Acute Purpura Hæmorrhagica in a Child" (a little boy, aged 3 years) is reported by Dr. Gibbons (*Medical Times and Gazette*, January 3, p. 2). The case ended fatally, in spite of careful treatment.

Pemphigus.

"The bullæ of Pemphigus" have been examined with regard to the presence of micro-organisms in their contents (as stated by Gibier) by Dr. G. Thin (*Lancet*, May 30, p. 981). He gave a full trial to the various methods of staining and cultivation which are now employed, and always with an entirely negative result.

Hyperidrosis.

A very remarkable "Case of Sweating to Death" has been placed on record by Dr. Myrtle (*Medical Press*, February 25, p. 164). An old man, aged 77, was seized with slight rheumatism without fever, from which he obtained complete relief by small doses of salicylate of soda. In about three weeks he began to perspire rather freely, and continued to do so copiously at intervals for about ten days, when the pains left him completely. He was treated now for the sweating only, which continued, by arsenic, cinchona, and sulphuric acid during the day, and quinine and belladonna at bed-time, the body being sponged with solution of common salt containing eau de cologne and vinegar once a day, and the wet underclothing changed as often as practicable. The patient at this time felt quite well except for the sweating, had no fever, no thirst, and passed urine normal in character and quantity. The sweats used to come on quite suddenly, the sweat literally pouring out of every duct, and this would go on for ten minutes or ten hours, but invariably stopped as suddenly as it began; everything on or about him was simply saturated. Ague being suspected, Warburg's tincture was now given in full doses, and the quinine and belladonna continued, but no improvement took place, and later "the sweat became most offensive, giving the same heavy smell as that given off by a horse after a smart gallop on a hot day." The case being considered as due to paresis of terminal branches of nerves supplying the sweat glands, ergotine was tried, two doses of three grains each being given at an interval of eight hours; soon after the second dose toxic results ensued, from which recovery took place under stimulants, hot bottles to the feet, and sinapisms to the chest and nape of the neck, but the sweats were not controlled; in the following twenty-four hours fifteen distinct bursts of perspiration were observed, lasting from a few minutes to a couple of hours, and it was found that during the intervals the skin, although soft and sodden, was not wet, but during the attacks it was no sooner wiped dry than the sweat was again seen standing upon it. The next remedy tried was atropia, gr. $\frac{1}{30}$ being given morning and evening, the surface of the body being also dusted with salicylic acid and starch. In an hour after the administration of the atropia, severe symptoms of poisoning were developed, and the patient nearly died; he rallied, however, and then the sweating went on just the same. It was then decided that arsenic should be resumed, and accordingly five minims of Fowler's solution were given

twice a day, with Warburg's tincture, and in forty-eight hours the perspirations ceased and kept away for twenty-four hours; they then recurred slightly, but for a week there was so little sweating that recovery was anticipated, when they suddenly recurred, worse than ever. All this time there was no constitutional disturbance, the pulse was 72, and the temperature normal. The arsenic had to be stopped soon afterwards, owing to the development of dryness of the mouth and throat, with inflammation of the conjunctiva, and eucalyptus was now substituted, morphia being given at bed-time. The sweating, however, continued with unabated severity until his death, which took place from exhaustion in four months from the first onset of his illness.

Raynaud's Disease.

Two cases of this singular disorder were communicated to the Clinical Society on May 23 by Dr. Colcott Fox. 1. A nervous woman, aged 41, had suffered at least ten years; at first all her fingers continually went "like white wax;" this condition of local syncope gradually passed into local asphyxia, and the feet became involved. The fingers gradually became chronically cyanosed, this condition being intensified by frequent severe attacks, often leading to ulceration. The nutrition of the phalanges had suffered greatly, so that her hands were crippled, the fingers fusiform, livid, shiny, and withered, the nails variously distorted, and the end-phalanges much atrophied and almost immovable. The nose and ears were somewhat affected on exposure. Cold and nerve-shocks were ready exciting causes.—2. A man, aged 51, with diabetes. He had suffered for several years from dead fingers, but there was no deformity. Symmetrical gangrenous patches appeared on the skin, and there was marked local asphyxia of the big toes. There was no hæmoglobinuria in either case. Mr. Cripps (who thought the second case was one of diabetic gangrene) thought that these cases were not far removed from frost-bite and senile gangrene, between which Raynaud's disease seemed to hold an intermediate place. Many of these patients had cold extremities, which at length became gangrenous when the weather was very cold. Dr. Barlow said that Raynaud had recommended the use of the constant current for these cases. A patient of his own, a man aged 42, for two years had suffered so severely in the feet that he could not walk, and was not entirely well even in the summer. Last autumn the constant current was applied, one pole to the spine and one to the extremities; but this was useless. It was then tried with both poles to the extremities, and kept up for about twenty minutes a day to each extremity for eight months, with benefit. The feet soon had a warm glow, and the result apparently had been permanent. The man now shampooed his feet every day, and could do his work. In two other cases, in children, which he had already communicated to the Society, the attacks only came on when the cold weather appeared. The paroxysms usually lasted about two hours, and came on at nine and five o'clock every day. The feet were quite cold, black, and intensely painful. In one attack, ten minutes after its commencement, a bath of salt and water was used; one pole of a Leclanché battery was applied to the limb in the water, the other pole some inches above the ankle, and the benefit was considerable. In another patient he had also tried galvanism, and the benefit was great. He had tried nitrite of amyl; the face flushed, but it had no influence on the local condition of the extremities. At the same meeting of the Society, Dr. A. T. Myers showed a case of Raynaud's disease affecting the ears, with paroxysmal hæmoglobinuria. The patient was a boy aged 12, and both ears showed

scars of symmetrical gangrene, from which he suffered for about two years. Since then there had been cyanosis, tenderness and aching of the ears on any slight exposure to cold, but no actual gangrene. Together with the first appearance of gangrene, attacks of paroxysmal hæmoglobinuria came on, and had continued ever since. Neither syphilis nor malaria could be traced in the history of the case. This patient was for some time under the care of the present writer, together with another, a man aged 34, who was affected in a precisely similar manner, with the exception that the gangrenous or ulcerative process was active in his case; it was also quite limited to the ears, which were originally thought by Raynaud to be exempt from actual gangrene, although they were often attacked with cyanosis occurring paroxysmally. This patient had suffered from ague eight years before the first appearance of hæmoglobinuria, which preceded the local asphyxia by about a year.

JOHN CAVAFY.

LONDON.

Selections.

URETHRAL INJECTIONS IN GONORRHOEA.

THREE principal points are to be considered in the study of urethral injections: their composition; the time when they should be employed; the mode of employing them.

THE COMPOSITION OF INJECTIONS.

The general principle may be laid down that every urethral injection should be antiseptic or at least aseptic, that is, it should not contain germs. The importance of urinary antiseptics is recognized by every careful surgeon, and every one who performs a lithotripsy, a dilatation, or even a simple catheterism, pays particular attention to the cleanliness of his instruments. But in the case of injections it is quite different, and I am not aware that any one, until now, has formally laid down the principle that an injection should be aseptic, nor urged that careful precautions should be taken in order to assure asepsis. While many injections recently recommended have for their base antiseptic substances, the object has been to destroy the pathogenetic microbe of gonorrhœa and not to obviate the danger resulting from the penetration of morbid germs. It is not sufficient to know that the bichloride or the permanganate will destroy the gonococcus, it is also necessary to recognize the fact that an injection, regarded as inoffensive, may constitute a source of danger.

I have examined, from a microbial point of view, a large number of specimens of urine in cases of cystitis consecutive to gonorrhœa. In the pus of some of these cases of cystitis, I have not found organisms, in some I have found the gonococcus, and sometimes I have found multiple varieties of organisms, most often bacilli of different sizes and diverse forms.

When we inquire into the history of patients of this last category, we find that during weeks and sometimes months they have been forcing into their urinary passages various injections. It is probably not necessary that the injections should have been passed beyond the anterior urethra in order to infect the deeper parts; in coition, for example, the gonococcus is certainly not deposited deep within the canal, but this does not prevent its progression, since it finds only a

feeble barrier in the urethral sphincter. It is not only necessary that the injections should not contain germs, but it is quite as necessary that the receptacle in which it is placed and the syringe with which it is used should likewise be aseptic. Preliminary boiling appears to be the best practical means of assuring the disinfection of the injection. Quite a number of efficacious agents in the treatment of gonorrhoea, as the sulphate of zinc, or tannin, or the salts of lead, are not antiseptic in the proper sense of the word. I think it prudent to even boil antiseptic solutions, since the proportion of the active substance must be feeble in order that the injection be not irritating.

It should not be forgotten that the solution is not deposited upon a healthy tissue, but upon a tissue swarming with microbes. Strong antiseptic injections are positively injurious, since they are always certain to irritate the membrane without ever being sure of destroying all the germs, and the germs which survive have in the inflamed tissues more favorable conditions of development. Another general principle in regard to injections is that they should contain no solid particle or at least only a state of extreme subdivision. One may readily conceive that a solid particle may lodge in an anfractuosity of the urethra and become the point of departure of a concretion.

Injections turbid and thickened with salts of lead or vegetable extracts are open, though in a less degree, to the same objections as the subnitrate of bi-muth.

Injections which do not stain the linen should, other things being equal, be preferred. Nitrate of silver possesses this inconvenience, and, moreover, it allows the deposition of a precipitate of chloride of silver, when brought into contact with the chlorides, but this precipitate, on account of its fineness, is not so objectionable, and, besides, the nitrate of silver possesses so positive an efficacy that we should continue to use it. I ought to add that I employ it rather in instillations than in injections properly so called.

THE PROPER TIME TO BEGIN THE USE OF INJECTIONS.

The general principle may be laid down that an injection, practised by the patient, is really efficacious and without objectionable results only when the disease is limited to the superficial portion of the anterior urethra.

The injection exerts a local action either in killing the microbes or in placing the tissues which contain them in a state unfavorable to the development and reproduction of the germs. There are two conditions in which this action is impossible: 1st, when the gonorrhoea has been propagated to the posterior urethra and the bladder; 2d, when the inflammation of the anterior urethra indicates that the disease is not confined to the surface of the mucous membrane, but has invaded the deeper tissue. But how shall we determine whether the gonorrhoeal inflammation has or has not penetrated to the posterior urethra? There are conditions in which this diagnosis is quite simple. A patient, for example, presents himself with a recent gonorrhoeal epididymitis, or an evident cystitis, characterized by frequency and pain of micturition and the expulsion at the end of urination of a few drops of blood. No one under such circumstances would prescribe injections. He should employ internal treatment, or have recourse to instillations of nitrate of silver, which sometimes give excellent results, especially in quieting the symptoms.

It may be laid down as a safe rule that, if the vesical urine is clear, the proper time for making injections has arrived; if the urine is turbid, it is better to wait.

The anterior urethra may be cleansed with the *sound à boule*, and then have the patient urinate, or to insure an absolutely exact diagnosis, *lavage* of the urethra is to be preferred. For practical purposes it will be sufficient to have the patient pass urine in a number of glasses. If only the contents of the first be turbid and the others clear, and if at the same time rectal exploration indicates that the prostate is neither swollen nor painful, we may infer a non-implication of the deeper parts and order injections.

A point of special importance should be here indicated : gonorrheal epididymitis is a very evident proof of profound propagation. Is it then necessary to await the complete resolution of the epididymitis before ordering injections? To this question we may answer, No : it is only necessary, other conditions being favorable, that the painful period of the epididymitis be passed. Notwithstanding the persistence of epididymal induration, although it be somewhat sensitive, if we find that the vesical urine is clear, injections should be prescribed. It now remains to indicate the diagnostic signs of the inflammation being limited to the superficial portion of the mucous membrane. The most useful criterion is the absence of local signs of inflammation. To prescribe an injection when the meatus is red and swollen, when the discharge is yellow and abundant and tinged with blood, when the passage of the urine causes acute pain, while there is present oedema of the prepuce or sheath, is not only useless, but may cause an aggravation of the malady. When, on the contrary, the meatus has become pale, the discharge rather white than yellow and a little stringy, when the pain in urinating has ceased, when the local oedema has disappeared, when the palpation of the penis, and pressure exercised along the course of the canal, does not provoke pain, we may conclude that the anterior urethra is in a state to receive injections with advantage. One other point : At the *début* of the disease, within twenty-four or thirty-six hours after the first appearance of the discharge, there exists an apparently favorable condition for the employment of the abortive treatment by injections. Since Musitan, who employed calomel, numerous authorities have proposed formulæ for abortive injections, but the majority employ by preference nitrate of silver. I have not had occasion to employ the abortive treatment. This question of abortion should be determined from the absolute diagnostic point of view, which the presence of the gonococcus alone can give. I do not know of a single case of recent gonorrhoea where the diagnosis has been established by the microscope, and in which the abortive treatment proved successful.

HOW SHOULD URETHRAL INJECTIONS BE PRACTISED?

We have now principally in view injections practised by the patient himself and not by the surgeon. It may be necessary to carry a medicated injection into the posterior urethra or into the bladder, but this should only be done by the surgeon. The patient should never go beyond the anterior urethra ; the problem to be resolved consists then in finding the means which will enable the patient to carry an injection along the entire extent of the anterior urethra, comprising the cul-de-sac of the bulb, without penetrating the deeper parts. The syringes ordinarily employed for injections are too large. Four to five grammes of fluid are quite sufficient to fill the anterior urethra of the adult. This quantity should not be exceeded when the injection is practised in the ordinary manner with the meatus closed. The method which I recommend is to introduce a small supple tube of rubber, twelve to fourteen centimetres in length, size No. 10, scale of Charrière.

This tube, not greased, but simply moistened in the injecting fluid, is gently introduced, with the fingers clean and well washed, and carried nearly to the bottom of the anterior urethra. It should project one or two centimetres from the meatus, the point of the syringe filled with the injection is fitted into its external orifice, and the fluid is forced through the tube, *care being taken to have the meatus open*. The fluid necessarily passes to the bottom of the anterior urethra and passes out freely through the meatus, coming in thorough contact with every portion of the canal. The suppleness of the tube does not permit it to readily pass the urethral sphincter, and the injection made with the meatus open is not forced beyond the sphincter.

By employing injections in this way, neither microbes nor foreign bodies are introduced into the urethra, and the local action of the remedy is directed to the seat of the disease without exceeding its limits. These simple ideas have never before been formulated. The treatises on venereal are full of the most varied formulæ, but we vainly search for precise rules of practice in the employment of injections.

Injections employed according to the conditions I have indicated have a positive effect in shortening the duration of gonorrhœa, without exposing the patient to certain accidents with which they have sometimes very justly been reproached.—M. AUBERT, *Lyon Médical*, Jan. 3 and 10, 1886.

CONTRIBUTION TO THE STUDY OF QUININE ERUPTIONS.

1. QUININE employed internally can at times produce eruptions.
2. These eruptions take on a multiplicity of form, of which one, the scarlatini-form, is of peculiar interest. These eruptions appear suddenly, become general with great rapidity, and are most frequently fugacious.
3. They may, in certain cases, be preceded by general phenomena of marked intensity.
4. They recur with the greatest facility under the influence of a renewed dose of the medicine.
5. The diagnosis may be obscured by the striking similarity of the scarlatini-form exanthem to that of certain eruptive fevers; and, to remove all doubt, you must, above all, take into consideration the fact of the recurrence.
6. The eruptions are extremely benign, and disappear generally in a day, exceptionally remaining several days.
7. They can be explained either by the elimination of the quinine through the sudoriparous glands, or by a special action which this drug has upon the circulation of the skin through the nervous system, and especially the vaso-motor nerves.—P. LAVASSAR, *Thèse de Paris*, 1885.

MELANOSIS OFTEN NOT BLACK: MELANOTIC WHITLOW.

WHEN melanosis fungates, and when it affects the glands, we must not expect the larger growths to be of a black color. The power of producing black pigment appears to be, in most persons, very limited. The original growth, beginning it may be in the rete of the skin, or in the choroid of the eye, is coal-black, but the later and larger growths are white, or show only here and there a pigmented streak. To make the diagnosis at these stages, it is necessary to look carefully at the skin near the margin of the fungus. Here a little colored border may often be found, looking as if lunar caustic had been applied, which tells the tale.

Melanotic Whitlow.—There is a rare form of disease of the nail-bed which is malignant, and usually takes the type of melanotic sarcoma. It is generally at-

tributed in the first instance to injury, and its diagnosis is always missed in the early stages. Because it resembles whitlow, and is usually so named at first, I prefer to give it that name. It is, however, from the beginning, malignant. Careful observation will find at the edge of the inflamed nail a little border of coal-black color, and this, however slightly marked, must be allowed to make the diagnosis. I have seen at least half a dozen of these cases. Early amputation is demanded.—J. HUTCHINSON, in *Brit. Med. Jour.*

SQUAMOUS ROSEOLA IN ITS VARIED FORMS.

1. THE entire group of features presented by the affection to which Gibert has given the name of pityriasis rosea permits us to consider it as a pseudo-exanthem more closely allied to the eruptive fevers than to the dermatoses with which it was formerly classed.

We believe that we should consider it as a special morbid entity, to which the name roseola squamosa would be applicable.

2. It is important, as well from a diagnostic as from a therapeutic point of view, to be perfectly familiar with the mode of production of the successive blotches which, almost of themselves alone, constitute the disease, and present in their evolution the varieties of form and configuration.

3. The mode of production is cyclic and distinguishes this affection from the chronic and parasitic dermatoses with almost analogous lesions.

The furfuraceous desquamation, which led to its being first described as a variety of pityriasis, should be considered as secondary.—ALBERT CHAPARD, *Th. de Paris*, 1885.

RHEUMATIC PURPURA.

1. THERE exists a purpura of rheumatic nature which is a manifestation of the general rheumatic disease, in the same way as endocarditis, pleuritis, and polyarthritis may be.

2. This purpura is at times simple and at times hemorrhagic. This important distinction, for purposes of prognosis, is, in rheumatic purpura as in purpura of other origin, without consequence as regards nosology.

3. Simple rheumatic purpura is by far the most frequent.

Its duration and extension are very variable. At times a simple epiphenomenon, it may pass unperceived; at other times the exanthem attracts more attention than the rheumatism. In the latter case, the clinical picture is that of the *peliosis* of Schönlein and Fuchs.

4. To establish the rheumatic origin of certain purpuras, we have only taken the cases in which the joint affection was well marked, but it is proper to admit that a rheumatic purpura could exist without polyarthritis.—R. TEIXEIRA, D'AS-SUMPCAO, *Th. de Paris*, 1885.

SCLEROSIS OF THE EXTERNAL FEMALE GENITAL ORGANS.

PROF. BREISKY has made some observations on a new disease of the external genital organs in the female, characterized by a sclerosis and consecutive retraction of the integument. The changes may sometimes go on to such an extent that the nymphæ become gradually atrophied, and finally disappear altogether, simulating, if seen then for the first time, a congenital malformation of the parts. The affection begins in the fold where the labia minora unite with the clitoris, invading then the labia minora and possibly even the majora. As a consequence a stenosis of the vaginal orifice results at the level of the vestibule. When the dis-

ease has progressed to a less extent, it is characterized by a hardness and dryness of the skin and thickening of the epidermis.

Up to the present time the author has collected a dozen cases of this singular affection. He has only once succeeded in making an anatomico-pathological study of a case in which he found a true scleroderma. The papillary portion of the skin is especially subject to this sclerotic transformation.—*Rev. des. Malad. des Femmes.*

RETRACTION OF THE PENIS.

THE following remarkable case is referred to in the *London Medical Record*, February 15, 1886 :

A strong man of 33 came to a local hospital in the Samara Government with a string encircling the retro-glandular sulcus of the penis and firmly fastened to the thigh. When the string was untied the penis slowly retracted, and ultimately disappeared under the pubic arch, leaving only a navel-like depression.

Coaxing and threats were of no avail ; the organ would not present itself to view again until traction was made upon the string. The condition had been discovered five days previously by the patient, who, having got up to micturate at night, was surprised and shocked at his inability to find any organ with which to perform the act, being well aware of its existence at bed-time. After long and patient manipulation, he succeeded in bringing it to view, and at once secured it with a strong string, not wishing to risk its permanent withdrawal. There was no perineal pain, and no cause could be assigned for the strange retraction. Ten-grain doses of bromide of potassium were given every three hours. The following day the penis remained unretracted for an hour. Six days later the retraction disappeared and did not return. Dr. Ivanoff, who reported the case, could find no similar one in literature.

GANGRENE OF THE PENIS.

ORLOWSKI reports in the *Gaz. Lekarska*, No. 32, 1885, the case of a patient aged 32, who had congenital phimosis, and for a year had not had connection.

Fourteen days before his admission to hospital, a small sore appeared on the prepuce and the salivary secretion was increased.

Gangrene of the prepuce and glans came on in spite of various treatment, and at date of admission one-third of the organ was in a gangrenous condition. The gums were indicative of scorbutus, and the lower extremities were covered with scattered petechiæ.

In the course of twenty-five days, one-half of the penis fell off, and the stump healed, leaving a cicatricial stricture of the urethra. The author had observed one other similar case in a robust young man in whom there were no signs of scorbutus.

COCAINE IN MERCURIAL STOMATITIS.

In this painful affection which sometimes compels a suspension of treatment with mercury, Dr. M. Bockhart has found the hydrochlorate of cocaine in 5% and 10%-strength of great service. It is to be applied to the gums with a camel's-hair brush about five minutes before each meal, and will enable the patient to chew his food without pain. In some very bad cases it may be necessary to use a 20%-solution ten minutes before meal times, and repeated in five minutes. He directs that the brush be always disinfected with carbolic acid after use, as the bacteria from the mouth adhering to the brush very soon spoil the cocaine solution.—*Monatshft. f. prakt. Derm.*, Feb., 1886, f. 67.

JOINER'S VARNISH IN BURNS AND SCALDS.

DR. KRASSOVSKY, of Yaransk, Viatka Government, reports (*Proceedings of the Viatka Medical Society*, Nos. 10, 11, and 12, 1885, p. 18) that in two cases of burns of the second degree, he has obtained excellent results from repeatedly painting the parts injured with the common alcoholic varnish used by joiners. Pain immediately disappeared, and when the film of dry varnish fell off, it left the sound skin covered with epidermis. The author concurs with Dr. Svislovsky in that this plan of treatment is applicable only in cases where the cuticle remains unbroken. The author borrowed the use of varnish in burns and scalds from popular medicine, the method being extensively practised by peasants and artisans of the Yaransk district.—*London Lancet*.

ICHTHYOL IN SHEETS.

DR. GÉCÉ has devised a means of applying ichthyol which appears to have many of the advantages of the "fixed adhesive dressings," being protective, supple, adherent, easy of application, and not requiring frequent renewal. It is made in thin sheets, which are directed to be cut into strips, moistened in hot water, and applied to the diseased part. It adheres perfectly, and forms, as it were, an artificial epidermis. Its renewal is required every three or four days.—*Gazette des Hôpitaux*.

 Review.

THE STUDENT'S MANUAL OF VENEREAL DISEASES. By BERKELEY HILL, M.D., and ARTHUR COOPER, M.D. Fourth Edition, revised. Philadelphia: P. Blakiston, Son & Co., 1886. 12mo, pp. xiv., 132. Price \$1.00.

THE fourth edition of this little book attests its popularity. It is a practical, concise treatise, written in an attractive style; a very readable book. Two-thirds of its pages are devoted to syphilis, the remainder being given to chancre, gonorrhœa, and accessory venereal disorders. We note that the term "*chancre*" is not used, "*chancre*" being the proper name for this lesion; while what we commonly call chancre in this country is rightly spoken of as the "initial" lesion of syphilis. We regret to see the terms "leprosy syphilide" and "lepra" of the palms and soles, used on page 33; a misuse of terms that is confusing, and should be allowed to sink into oblivion, "squamous syphilide" being an infinitely better name. The authors take a cheerful view of the course of syphilis, and teach that the great majority of cases subside completely within two years, many ending spontaneously. In the treatment of this disease, we are told that the red or biniodide of mercury is specially useful in relapses of the scaly eruptions on the skin; and the green or protiodide sometimes fails to produce any effect, and is apt to cause griping and purging. It is advised to administer the iodide of potassium with the aromatic spirits of ammonia to increase the activity of the iodide and prevent its depressing effect.

Mention is made of the *bacillus* of syphilis and the *gonococcus* of gonorrhœa, though they are not recognized as proven. Otis' coil is recommended in the treatment of rupture of the erectile tissue of the penis. At the end of the book we have directions for the mercurial vapor-bath, and for making urethral injections. Also a number of formulæ which the authors have found useful. The book is a credit to the publishers, as it is printed in clear type and neatly bound.

G. T. J.

Items.

BROKEN GLASS IN THE VAGINA.—A lady, aged 47, came to Dr. Angus on account of a displacement of the womb. Vaginal examination showed a hard round body lying to the right and posterior side of the cervix uteri. After some difficulty he succeeded in dislodging it, and found it to be the broad perforated end of a broken glass female syringe. The patient was amazed, and said she remembered, *seven months previously*, breaking a syringe when using a vaginal injection, but, hearing her husband coming up-stairs, she put the fragments into the chamber-vessel, and thought no more of it. Connection had taken place several times, the husband complaining of feeling some obstruction, but the patient had herself never experienced any inconvenience.—*Brit. Med. Journal*.

EARLY GONORRHOEA.—Dr. E. B. Ward, of Greensboro, Ala., reports two cases of early gonorrhoea in negro boys, aged 7 and 9 years respectively. Dr. Fenn, of San Diego, Cal., writes to the *Journal of the Amer. Med. Assoc.*, Dec. 12, 1885, that he has recently treated a lad of five years for undoubted gonorrhoea, who acknowledged that he had been toying with a dissolute girl of about twice his own age.

THE CONSEQUENCES OF PHIMOSIS.—Most text-books merely point out the possible danger of a phimosis causing distention of the bladder from the unnatural impediment to the outflow caused by it, and consequent implication of the pelvis of the kidneys through the ureters.

Dr. Hans Schmid has called attention (*Centrab. f. Chir.*, 28, 1885) to the frequent coincidence of inguinal, crural, and umbilical hernia, prolapse of the rectum, hydrocele, and, especially, obstinate eczema and intertrigo with this condition.

HORNY GROWTH AT THE EXTREMITY OF THE PENIS.—The *Indian Med. Gaz.*, Jan., 1886, gives an account of a Hindoo, aged 60, who had had gonorrhoea followed by phimosis fifteen years ago. Circumcision had been performed, in consequence of preputial irritation, eight months previously, and the growth had developed since then. There were two well-marked horny projections growing from the corona glandis, and the surface of the glans was covered with a cap of similar material. Amputation of the glans, including the growth, was performed with satisfactory result.

CATHETERISM ALMOST PAINLESS.—Dr. John A. Stamps recommends (*Medical and Surgical Reporter*) the following as an almost painless method of catheterizing an hyperæsthetic urethra: Inject through the catheter, as it is being introduced, water as warm as the patient can bear. The water regurgitates between the catheter and the urethral wall, and the warmth of the water will, in many instances, serve to allay all urethral irritability.

GONORRHOEAL WARTS.—Nusbaum washes gonorrhoeal warts twice daily with salt and water, and then sprinkles them with calomel. The reaction of the residual sodium chloride and calomel produces mercuric chloride. This treatment, he claims, cures the warts rapidly, without causing pain or detention from business.—*Med. and Surg. Reporter*.



Fig. 1.



Fig. 3.



Fig. 2.



Fig. 4.

1. Variola. 2. Scarlatina. 3. Rubella. 4. Roseola.

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AN ADDITIONAL NOTE ON DOUBLE COMEDO.

BY

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THE February number of the JOURNAL contained an article, written by me, descriptive of a form of comedo hitherto unmentioned.

Two cases were described at that time, and there were several points which required elucidation. Since that time, I have observed two more cases, and they throw some little light on a few of the obscure points mentioned before. A brief record of these cases may not prove uninteresting and is introduced, so that the contrast afforded by these with the first two recorded may be more easily seen.

CASE I.—A. U—— is about 19 years of age, rather inclined to a light complexion, and rather slight in build. He has never suffered from any other skin disease, nor did he ever have syphilis. He seems to be fairly well nourished, complaining only of constipation in a moderate degree. For the past six months or so he has been troubled with comedo, accompanied by a mild eruption of acne. The comedones are, for the most part, small, and the plugs inspissated to a high degree. The regions chiefly attacked are the hairy portions of the face, about the alæ of the nose, and along the border of the scalp, the ears being also implicated. Milium also exists to a limited degree. Improvement has been marked under a treatment consisting of laxatives internally and Unna's acid paste alternated with hot water applications, followed by a sulphur ointment, together with the daily expression of comedones. The double

comedo, which is present, is analogous to that observed in the next case, and will be described more in detail later on.

CASE II.—H. G—— is 21 years old, rather heavy-set, and of a lymphatic temperament. He is a blonde, and of German extraction. He has never had any skin disease anterior to this one, and never had syphilis. Some six months ago I treated him for a chancroid, which rapidly healed. He is well nourished, and all of the functions of his organism apparently properly performed. He is troubled with comedo of the face, the comedones being fine and discretely distributed over the face. The same local treatment was ordered as in Case I. Although the trouble had lasted nearly a year before I saw him, the progress toward recovery was very satisfactory, and he will probably be entirely rid of the comedo in a comparatively short space of time.

CASE III.—T. J. W——, aged 52, has had comedo for a long number of years. He has never been troubled by any other affection of the skin with the exception of rosacea. He has always enjoyed the best of health, and has never done anything for the comedones except pressing them out. He is almost entirely rid of them, but here and there can be seen double comedones, which are similar to those existing in Cases I. and II., and which have been described in a former paper.

In all of these cases the double comedones occur upon the face, and their site of predilection is near or about the malar eminences. Each opening is separated a little more than one-sixteenth of an inch from its fellow, the bridge of integument between the two being quite firm and well developed. Upon exercising pressure laterally, the plug is easily expressed and found to have both extremities black. A fine probe is readily passed through the opening thus left, and the existence of this horizontal tunnel clearly demonstrated.

These cases are interesting, as they elucidate at least one point, viz., that this condition of the tissues is not pathological, that it is an anomaly due to no destructive process, and that syphilis plays no part whatever in its production—a point which could not be definitely settled by the first two cases observed.

Again, in the first two cases, the condition was observed upon the back, whilst in those just recorded it is observed in the face.

I have come to the conclusion that double comedo is not, by any means, an uncommon thing, and that if observers will take a little more pains in examining the cases of comedo which come in their hands, they will soon note its comparative frequency. As to the true anatomical condition of the parts involved, I am unable to furnish any information at the present time. I, however, expect before long to obtain specimens from which sections can be made, and the relations established between the ducts of the sebaceous gland and these double openings upon the

surface. Should I succeed in this, it will form the basis of a note which will fittingly conclude the subject, which has so far elicited but little attention.

903 OLIVE STREET.

ARSENICAL ERUPTIONS.¹

BY

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Clinical Professor of Venereal Diseases in the University of the City of New York, Surgeon to Charity Hospital.

THE cutaneous eruptions which follow the external and internal use of arsenic are similar in character. While the external contact of arsenic produces certain changes in the skin which can in no way be distinguished from a dermatitis caused by other local irritants, the severer eruptive forms are probably due to absorption of the drug, and its specific action through the blood upon the skin. The irritant effect of the external application of arsenic was known to the writers of antiquity, and has since been studied by numerous observers.

If arsenious acid in a watery solution, or in the form of an ointment or paste, be applied to the healthy skin, there results inflammatory redness, and, if the contact be continued sufficiently long, vesicles, pustules, etc., will form, attended with sensations of heat, burning, and pain, precisely as in the application of other vesicants. The hairs on the affected surfaces generally fall out, and there is exfoliation of the epidermis in large flakes. A higher degree of inflammatory disturbance is manifest in the production of erysipelatous swellings, sanguinolent eruptions, and ulcers, attended with toxic effects similar to those consequent upon the internal administration of the drug. Numerous cases are on record where arsenical lotions, plasters, and pastes have proved fatal. The application of an arsenical ointment (1 to 32) to a cancerous breast covering the space of one and one-half inches, for one night only, caused death from poisoning on the second day. A strong application of arsenic is much safer than a weak one, since the intensity of the inflammation it excites interferes with the action of the absorbents, and the effect remains local.

Abundant opportunities for the study of the changes in the skin caused by external contact have been afforded by the extensive use of arsenic in the form of lotions for the complexion, dusting powders, etc. A remarkable skin affection which prevailed among infants and children in

¹ From a forthcoming work on Drug Eruptions. Wm. Wood & Co., Publishers, New York.

Brighton in 1818, at first thought to be erysipelas, was traced to the use of a dusting powder containing fifty per cent of white arsenic. Of twenty-nine attacked, thirteen died. The cases were carefully studied by W. H. Power,¹ and the character of the eruption may be briefly described as follows: In very mild cases there was erythema and the formation of minute vesicles; in severer cases blisters and bladders formed in the creases of the skin where the powder was applied, some of the bullæ, when collapsed, left black excavated sores, with indurated and discolored edges. In fatal cases there was a generally blackened condition of the skin of the groins and pudenda, which quickly became somewhat swollen and hard. A like condition upon the abdomen was occasionally observed about and below the umbilicus, as also the skin of the axilla and folds of the neck. Invasion of these several parts where it occurred was simultaneous. In some instances vesication, variously described as "little white blisters," "yellowish bladders," or "bags of water," preceded or appeared about the same time as the blackness. The vesicles breaking discharged clear fluid and left raw black surfaces, which did not, it would seem from the description, take on suppurative or sloughing action. The average duration of the fatal illness was four or five days. The eruption was localized on parts of the body to which the powder was applied.

The various industrial uses of arsenic in the manufacture of artificial flowers, green-colored cards, paper boxes, wall paper, and carpets, fixing dyes, etc., are the prolific source of numerous forms of eruptive disorders.

It is well known that persons who wear cheap underclothing colored with fuschine, containing a large percentage of arsenic, or socks died with the same material, are subject to eczematous eruptions on the parts exposed to contact with the coloring matter. Seifert² reports the case of a lady who had been wearing stockings colored with an aniline red containing arsenic. She was suddenly seized with all the symptoms of a gastro-enteritis and an acute hemorrhagic nephritis, besides an eczematous eruption on the dorsal surfaces of both feet. The urine for some time afterward contained a small amount of albumin. Impetiginous eczema has been seen on the arms of a lady who wore a bracelet composed of a paste containing a large proportion of arsenite of copper. According to Rollet,³ who has made a careful study of the cutaneous lesions from the industrial uses of arsenic, erythema is the first degree of arsenical dermatitis. Generally upon the erythema are devel-

¹ Power, W. H., "Rep. Med. Off. Local Government Board," London, 1879, p. 31.

² Seifert, Wiener Med. Wochenschrift, 1885, No. 38.

³ Rollet, Annales de Dermat. et Syph., Tome I., 1880, p. 1.

oped other elementary lesions; papules which enlarge and extend and are covered with small scales of greenish tint, fine, transparent vesicles, and finally pustules. These pustules form with conical projections, red at the base, purulent at the summit, and are covered with a small opaque, yellowish-green crust. If the irritation continues, the pustules become the points of departure of ulcerations, which progressively increase in breadth and depth. Arsenical eruptions are situated upon parts exposed to contact with the irritating cause, as the face, forearms, hands, interdigital spaces, also the feet and inguino-scrotal region. The genital parts are peculiarly susceptible to the irritant action of arsenic. Frequently there are large ulcerations with œdema of the scrotum.

I observed several years ago at the New York Dispensary an eczematous eruption, with deep-seated pustules, on the hands of two young women who were employed in a paper-box manufactory, in which variously colored glazed papers were used.

White¹ reports several cases of arsenical dermatitis, one of intertrigo in an infant, and brown spots resembling pityriasis maculata et circinata of the mother, which were probably due to absorption of arsenical pigments contained in the wall paper, as every other possible factor was eliminated—a theory sustained by the fact that there was immediate improvement upon removal of the patients from the room. Clarke² records eczematous eruptions and nasal ulcerations as due to the emanations from arsenical wall papers.

Devergie was the first to signalize the fact that cutaneous lesions may be caused by the internal use of arsenic. The most complete and careful study of the arsenical eruptions has been made by Imbert Goubeyre,³ and embodied in his admirable monograph upon this subject. According to this authority, the pathogenetic influence of arsenic may be manifested in the form of papular, petechial, urticarial, vesicular, erysipelatous, and pustular eruptions. To these may be added an erythematous or scarlatiniform eruption, the occurrence of which has been attested by numerous observers.

The various preparations of arsenic differ in no sensible degree in their effects upon the skin, so that observations relating to arsenious acid will apply to Fowler's solution, the arsenite of soda, Asiatic pills, etc.

The Erythematous Form.—Although an erythema is the commencing stage of several of the forms of arsenical eruption, it rarely represents the acme or completion of the inflammatory process. Pereira observed in a gouty patient, after taking $\frac{1}{6}$ gr. arsenious acid a day, on the third day an intensely red eruption on the face, neck, upper part of the body, and

¹ White, Boston Med. and Surg. Journal, Nov. 6, 1884.

² Clarke, British Medical Journal, Vol. 1, 1873.

³ Imbert Goubeyre, "De l'action de l'arsenic sur la peau," Paris, 1871.

flexor surfaces of the joints, with œdema of the eyelids. The eruption disappeared between the third and fifth days, but desquamation in large flakes continued for nearly two months.

Macnab¹ has observed a rubeola-like exanthem in patients who had taken small doses of arsenic, three-drop doses of Fowler's solution daily for three weeks.

Hyde saw in a young woman who had taken only three medicinal doses of Fowler's solution, a light-red scarlatiniform blush, with few isolated vesicles, covering both shoulders, the eruption being present, but less distinct, on the hands and face. Piffard² gives numerous references of erythematous and rubeoloid eruptions consecutive to the internal administration of arsenic.

The Papular Form.—According to Imbert Gourbeyre, the papular form occurs as discrete, pin-head-sized papules, first in scattered groups, which unite later to form lenticular papules, occasionally large disseminated patches, which sometimes resemble a papulo-syphiloderm, although of a less coppery hue. The parts affected by preference are the face, neck, hands, and genital organs. The eruption usually disappears in five or six days, followed by furfuraceous desquamation. In one case the papules increased in numbers until they gave the skin the appearance of a "goose-flesh." The eruption was attended by decided itching, and lasted some days after the discontinuance of the medicine. Stewart³ reports the case of a powerfully built man, who was ordered five-minim doses of Fowler's solution after each meal. After the sixth dose he felt feverish, and he noticed that his hands and arms were red, swollen, and very hot; the redness of the skin spread rapidly, until it involved the entire surface, except the face. The skin was covered with countless papules, about the size of millet seeds.

Keyes⁴ reports after the use of arsenic, doses not stated, a papulo-erythematous eruption, dry and livid, on wrists and neck. General papular eruption on trunk and extremities attended with pruritus. Baglie observed dryness of the skin, heat, and itchiness of the eyelids with the production of a minute papular rash, followed by desquamation.

The Urticarial Form.—Fowler,⁵ whose name is so well known in connection with this drug, in his medical reports on the effects of arsenic, was the first to instance urticaria as one of the results of its employment. According to Imbert Gourbeyre, it is one of the most frequent forms of arsenical eruption. The wheals are white or rosy-red, and extremely

¹Macnab, *Med. Times Gazette*, London, 1868, 1, p. 297.

²Piffard's "*Mat. Med. and Ther. of Dis. of the Skin*," p. 24.

³Stewart, *The Canadian Practitioner*, April, 1885, p. 103.

⁴Cited by Piffard.

⁵Fowler, "*Med. Reports of the Effects of Arsenic*," Lond., 1786, p. 97.

pruriginous, differing in no essential particular from urticaria as commonly observed. Berenguier reports the case of a young lady treated with arseniate of iron, which brought out a copious eruption of white, somewhat reddish elevations of the uniform size of a lentil, and accompanied by intense itching.

The vesicular form.—The occurrence of a vesicular eruption from the ingestion of arsenic has been recorded by numerous observers. This eruption may sometimes assume an eczematous character which, according to Balfour,¹ may prove extremely obstinate. Ringer says eczema or urticaria may arise, or perhaps vesication or mere desquamation with tenderness of the hands and feet; again he says in arsenical poisoning a petechial papulo-vesicular or wheal-like rash often appears from the second to fifth day.

Finlayson² saw an eruption of clusters of vesicles on an inflamed base, extending from lower part of the arm down the back of the forearm and hand, including backs of the fingers. Herpes labialis and preputialis have also been observed from the use of arsenic. It has been asserted that herpes zoster may occur as the result of the ingestion of arsenic in medicinal doses. Hutchinson,³ while not claiming that a causal connection has been absolutely demonstrated, yet suggests its extreme probability in view of the well-known fact that herpes zoster has been more often observed in patients who have been taking arsenic than in those not subjected to this medication. He reports a number of cases, fifteen or sixteen, in which the coincidence was so marked as to furnish strong presumptive evidence of an etiological relationship. His observations have been supplemented by the experience of many other dermatologists who have noted this coincidence.

The pustular and ulcerative forms.—According to Imbert Gourbeyre, the internal use of arsenic may produce a pustular eruption resembling variola, the lesions terminating in crusts or ulcerations leaving cicatrices.

Orfila has noted, as one of the toxic effects of the drug on the cutaneous system, an eruption of pustules on the face, shoulders, arms, and chest.

Bazin⁴ reports a case in which there appeared after minute doses of arseniate of sodium, continued for fourteen days—one-half of a grain altogether—an eruption of discrete pustules in various stages of development, limited to the hypogastrium and right flank. One of the pustular le-

¹ Balfour, Edinburgh Med. Journal, 1860.

² Finlayson, The Practitioner, London, July, 1878, p. 18. "Occurrence of herpes during administration of arsenic."

³ Hutchinson, St. Barthol. Hosp. Rep., Vol. ix.

⁴ Bazin, "Leçons Theoret. et Clin. sur les Affections Cutanées Artificielles."

sions has become transformed into an ulcer, a centimetre in diameter, surrounded by indurated and inflamed tissue. Near by were two large erythematous pustules just breaking down in the centres into ulcers; other lesions were passing from a papular into a pustular form. The evolution of the lesion through its various stages, from appearance of papule to cicatrization of ulcer, occupied only a few days. The patient rapidly recovered as soon as the arsenic was stopped. In this case, as in others, pustular lesions are the points of departure of the ulcerations encountered in various parts of the body, more especially in the head, limbs, and scrotum. Gangrene sometimes occurs around the genitalia.

Erysipelas with bullæ, erysipelatous inflammations about the face and eyelids, and eruptions of a petechial character, affecting by preference the trunk and genital parts, have been recorded by Bazin, Imbert Goubeyre, and others.

According to Morris,¹ boils and carbuncles occasionally result during a course of arsenical treatment. This statement is confirmed by Foster, Vaudry, and others cited by Piffard.

Brownish pigmentations.—Among the incidental effects of arsenic upon the skin may be mentioned certain grayish or brownish discolorations, which are especially liable to occur upon the face and various parts of the body, after its prolonged use. Wilson² reports the case of a patient with gutta rosacea, who had taken arsenic for two months, when there was noticed a change in the color of the skin, first over the abdomen, then on the neck, breast, face, and hands. The face was of a yellowish-brown color, the eyeball dark, the skin of the entire body more or less pigmented; chronic erythema affected the palms; there were hard dry points at the orifices of the sweat glands; the eyelids and the extremities were œdematous. In the June number of this JOURNAL will be found a case of arsenical dermatitis presented by me before the New York Dermatological Society. There was an erythemato-papular eruption, with a grayish-brown, almost black discoloration of the surface, especially marked over the abdomen and inner surface of the thighs. Guailo reports that, in fourteen children placed upon Fowler's solution for four or five months, there was observed a bronzed appearance similar to that of Addison's disease, beginning on the neck, extending to the chest, then to the abdomen and hands; at times it is seen on the back and legs. It disappears by desquamation in about four weeks. Bazin has characterized this pigmentation as a tint, comparable to the staining of nitrate of silver. This condition depends, according to Gubler, not upon a chemical combination, as is the case in argyria, but on abnormal pigmentation. Wyss³

¹ Morris, Malcom, Practitioner, 1880, p. 434.

² Wilson, Journal of Cutaneous Medicine, Vol. 1, p. 354.

³ Wyss, O., Archiv für Heilkunde, Bd. xi., 1870, p. 17.

saw alopecia areata developed by the prolonged internal use of arsenic. This result he thought due to the effect of the drug upon the trophic nerves of the hair follicles, causing disturbance of nutrition.

As regards the pathogenesis of arsenical eruptions, opinions differ. It is known that arsenic is eliminated not only by the kidneys, but by the glands of the skin, the mucous membranes, the salivary lachrymal glands, etc. Chatin¹ found arsenic in the contents of a bulla, and Bergeron and Lemattre² in the sweat of patients undergoing arsenical treatment; while Barella³ claims to have demonstrated the direct elimination of arsenic by the sweat glands. Therapeutically, arsenic has been classed as a neuro-tonic and is supposed to modify cell nutrition through its influence upon the peripheral nervous plexuses. In view of these facts, we can understand how it may cause disorders of the capillary circulation and disturbances of the nutrition of the skin, as manifested in the various forms of eruptive disorder above described.

The treatment of arsenical eruptions may be restricted to the simple expedient of suppressing the offending cause. In the more severe forms, the same local measures are to be resorted to as are indicated in dermatitis from other causes.

66 WEST 40TH STREET.

DERMATOSES OF THE EYE.

BY

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Surgeon to Charity Hospital.

(Continued from page 171.)

BENZOL IN EPITHELIOMA OF THE EYELID.

AT the April meeting of the New York Ophthalmological Society (*N. Y. Med. Journ.*, Sept. 26, 1885), Dr. Mathewson presented a case of epithelioma of the right lower lid, which he had first seen two years before, and had treated with applications of benzol. The tumor had begun as a warty excrescence one or two years before it came under treatment. The benzol was applied three or four times a week for about three months, when the growth had completely disappeared, leaving a smooth, depressed cicatrix.

In March, 1885, the man returned with the history of a small ulcerating spot having appeared some six months before at the outer edge of the cicatrix. When presented at the meeting in April, this had greatly

¹ Chatin, *Journal de Clinique Medicale*, 1848, p. 328.

² Bergeron and Lemattre, *Archiv. général. de Méd.*, 1864, II., p. 173.

³ Barella, *Journ. de Med. de Bruxelles*, Juillet, 1863.

improved under the same treatment. By May 1 it was nearly well again, but treatment was neglected, and by July there was considerable increase in the ulcerating surface. Benzol was now applied again from two to four times a week, and the disease yielded promptly to the treatment.

SEBACEOUS TUMOR OF THE LOWER LID.

Prof. Richet (*Gazette des Hôpitaux*, No. 67) recently operated on a sebaceous tumor of the lower lid of a young man, which had begun to form at the ciliary border, five and a half years before. Three years ago, it had been removed, but reappeared one year later.

It was the size of a hazelnut, and interfered with patient's comfort. A plastic operation was necessary to prevent cicatricial contraction.

The author had found in several similar tumors sarcomatous elements, and cited one case where the removal of what appeared to be a simple sebaceous cyst of the nose was followed by similar sebaceous-like growths in other parts, and finally by a generalization of the neoplasm and death; and thought perhaps sarcomatous elements might be found in this tumor to account for its recurrence.

XANTHELASMA.

Whenever the term xanthoma or xanthelasma is mentioned, we instinctively think of the eyelids. The disease is, however, not confined exclusively to this organ, and I have seen it affecting several other regions. Hardaway, Robinson, Barlow, and others have recently reported cases in which the disease appeared on the trunk and extremities. Still the lids are the seat of the deformity in by far the greater number of cases, without our being able to give any good reason for the fact. Indeed, we don't know much about the disease, at best. In my experience, it occurs more frequently in women than in men, and I have seen it in diabetes, in which disease it is said to be quite common. It has been supposed by many to have some connection with liver disorders, and Hutchinson has shown its pathological relations with icterus and arthritis.

A review of the study of the disease by Dr. Carlo de Vincentiis, of Palermo, will be found in the *Annales de Dermat. et de Syphilig.*, 1884, p. 80. He believes, from his examination of tumors removed from eyelids of a girl of 20, that the disease does not result from a fatty degeneration, as Baerensprung taught, nor from an inflammatory or infectious hyperplasia, as Balzer believed, nor yet that it is an hypertrophy, but that we have to deal with a true neoplasm.

In 1883, Balzer described microbes found in the granular matter of the tumors; but, so far as I know, they have never been shown to have a causative relation to the disease. He was led to seek for a cause in this direction

from the analogy existing between the disease and tuberculosis and leprosy, both of which have their bacilli.

Writers now generally agree that the disease consists in a new-growth. Robinson states that connective tissue forms the basis of the tumor in which fatty degeneration readily occurs.

Excision, carefully done to avoid ectropion, offers the best means of removal. Co-existing disorders, such as disease of the liver, diabetes, etc., should be discovered and treated. I have seen one case in a diabetic woman in which the tumor diminished as the diabetes improved. Legge has observed spontaneous resolution in a case. The administration of phosphorus followed by turpentine has, in the hands of Besnier, produced rapid disappearance of the tubercles.

MILIUM

or strophulus albidus is frequently found co-existing with xanthoma on the lids, and might be mistaken for it when large. Much more frequently, however, it is found alone. Though not confined to the eyelids, the growths are probably more often met with in this than in other portions of the face, and are more common in early childhood. Virchow regarded them as arising from the hair-follicles.

Robinson believes in some cases they are the result of miscarried embryonic epithelium from a hair-follicle, or from the rete. Most cases of milia, or the affection which commonly goes by that name, I believe are due to retention of sebaceous matter in the sebaceous glands and their ducts, and is closely allied to acne. The disease is readily cured by incising or puncturing each separate lesion, and evacuating the contents with a large comedo expressor, care being taken not to press upon the globe of the eye.

VESICO-PUSTULE OF THE LOWER LID AND ULCERATIVE KERATITIS FOLLOWING ACCIDENTAL VACCINATION.

The following rare and remarkable case is found in the January number of the *Recueil d'Ophthalmologie*:

An army surgeon, Dr. Senut, while engaged in collecting vaccine lymph from a heifer, had a few drops of pus to accidentally squirt upon the left eyelids from a pustule he was pressing. Four days later a papule appeared upon the lower lid and soon became a vesico-pustule, attended with œdema of lids and febrile movement.

Four or five days later the pustule ruptured, and was succeeded by an ulceration.

Three days later, a crescent-shaped ulceration appeared upon the lower part of the cornea. The intra-ocular tension became so great that paracentesis was at one time thought necessary. A cure was finally effected

by means of cocaine, atropine, and hot applications, but cicatrices were left upon both cornea and lid.

ECZEMA OF THE LIDS.

Eczema may attack the lids when the other regions of the face, and possibly of the body, are at the time entirely free. Such cases are at times regarded as blepharitis, but until the correct diagnosis be made and internal treatment combined with local means, the disease will prove rebellious. This disease is regarded by Dr. Burchard (*Monatshefte für Praktische Dermatologie*, No. 2, 1885) as a frequent cause of phlyctenular conjunctivitis and keratitis, and subsequent prolapse of the iris, partial destruction of the cornea, and consequent blindness.

The treatment consists in applying to the closed lids a three-per-cent solution of nitrate of silver, and drying immediately with a linen cloth, repeating the process several times at each sitting, all vesicles and pustules having been previously opened.

Applications are made at first each day, and, as improvement goes on, every second day. After a few brushings there is scarcely any pain.

An ointment composed of Ol. Cadini, 3 i.; Pulv. Zinci Oxidi, 3 iss., and Vaseline, ʒ i., should be constantly applied in the intervals. If this ointment should prove irritating to the eyes, a mild white precipitate ointment may be substituted.

To this local treatment should be added tonics, alkalies, or such constitutional remedies as the case may indicate.

PEDICULI PUBIS.

Pediculi Pubis of the eyelids appears like a paradox. Still, the name is a proper one, for the crab louse does not confine himself to the region of the pubes any more than the pediculus vestimenti remains continually upon the clothing. It is extremely rare to find the eyelids infested with this parasite. I recently saw an instance in the case of a young girl at the clinic. She came complaining of itching and soreness of the lids. I looked carefully at her eyes, and told her she had suffered from itching about the privates for some time. She looked surprised, but said she had. I then told the students that the cause of this itching about the external genitals was due to crab lice. Looking into the eye and discovering pediculosis pubis was considered a brilliant diagnosis until I pointed out to them that a line of brown points along the edge of the lids between the lashes were really the parasites, and detached some of them from the hairs to which they were clinging by their powerful claws.

Treatment consists in the thorough application of a diluted citrine ointment to the lids, and removal of the parasites at the same time that

their destruction is accomplished on other regions of the body, with ointment or wash of staphysagria, carbolic, or one of the mercurials.

Many diseases of a constitutional nature having their most prominent lesions or manifestations upon the cutaneous surface, give also at times marked changes in the eye.

In lepra, for example, which has advanced to a considerable extent upon the skin, we at times find lesions of the cornea, and subsequently tubercles in the cornea.

The eye lesions of syphilis are so numerous and interesting that I shall reserve their consideration for some further notes at another time.

102 EAST 57TH STREET.

Correspondence.

A "TROUBLESOME CUTANEOUS DISEASE."

PORTSMOUTH, N. H., May 22, 1886.

To the Editor of the Journal of Cutaneous and Venereal Diseases.

DEAR SIR :—There is a troublesome cutaneous disease, of an epidemic character, very prevalent in this section, and I do not know what category to place it under. It has the general appearance of an eczema papulosum, with violent itching, especially at night; but its principal characteristic is its contagiousness; whole families are affected with it. I have been consulted by patients as far east as Eastport, Me., who tell me a great many are afflicted by it in that neighborhood.

The first cases I saw during the winter, and called it *pruritus hiemalis*, ignoring its contagious character; but cases seem to be as frequent now as during cold weather, and I am puzzled as to the nature of the trouble. A simple ointment of ammon. hydrarg. seems to be the most efficacious remedy, but some cases resist this treatment. I hope that you or some one of your dermatological correspondents may throw a little light on this disease through the columns of your JOURNAL, for the benefit of yours very truly,

A. B. SHERBURNE.

The disease which puzzles our correspondent is probably identical with a pruritic affection widely prevalent in the West, and which in different localities has received the euphonious titles of "swamp itch," "prairie digs," "Ohio scratches," "Michigan itch," etc. It has been confounded with scabies, but positive evidence of its parasitic origin was not revealed by the presence of the *acarus* in any of the numerous cases examined. The failure of the time-honored remedy of sulphur and lard, with which patients were in many instances copiously anointed, also furnished negative evidence as to its parasitic nature. Presumptive proofs of its contagiousness were found in the fact that often several members of a family were attacked at the same time, or successively.

We think the original diagnosis of our correspondent correct. The "itching disease," above alluded to has been carefully studied by Drs. Hyde, Hardaway, and others, and its identity with *pruritus hiemalis*, or the winter prurigo of Hutchinson, has, we think, been conclusively established. It is due essentially

to climatic conditions, its advent is made with the cold weather, and it is more prevalent in localities where severe changes of temperature occur. The explanation of its apparent contagiousness, as in cases where entire families are simultaneously affected, may be found in the fact that all are equally exposed to the same atmospheric conditions.

It is proper to say that many observers do not recognize cold weather as the chief etiological factor in the production of this disease, but the theory is quite consistent with the facts of our knowledge respecting the influence of temperature changes in the causation and aggravation of cutaneous diseases. The direct irritant effect of heat and cold upon the skin is a matter of common observation. The action of heat is familiarly manifest in the production of sunburn, prickly heat, *eczema solare*, etc. Many of the cutaneous disorders which prevail among our tenement-house population in this city during the hot summer months are directly traceable to the extreme heat. Chapped hands and faces, and a general roughened condition of the surface exposed to the action of cold, are no less familiar phenomena.

In the disease under consideration, however, the primary influence of the cold seems to be limited to the production of an irritable condition of the skin characterized by intense pruritus, always aggravated at night. The papular, vesicular, or other lesions are secondary, and superinduced by irritation of the skin from scratching. In exceptional cases a dermatitis, presenting a clinical resemblance to papular or vesicular *eczema*, develops without antecedent history of pruritus. In aggravated cases, pustular and furuncular lesions may occur. An urticarial form has also been observed, which presents certain analogies with the urticaria of immigrants, so common in our sea-board cities, and which is recognized as due to a change of climatic and dietetic conditions.

The treatment should be local and directed principally to the mitigation of the subjective symptoms. Turkish baths constitute a most efficient means for the relief of cutaneous pruritus, but these are rarely available. Hot alkaline baths prepared by the addition of six or eight ounces of the bicarbonate of soda, employed at bed-time, afford great relief. After an immersion of fifteen to twenty minutes in the bath, the skin should be carefully dried and an inunction made with carbolized vaseline or a soothing ointment. The anointed parts may then be dusted with Pears' fuller's earth, a mixture of starch and rice flour, or any of the ordinary dusting powders. Lotions of carbolic acid (five to ten grains to the ounce; with a little glycerin) or an ointment of carbolic acid (fifteen to thirty grains to the ounce) have an excellent antipruritic effect. When the skin is not broken, painting the affected surfaces with a solution of carbolic acid in glycerin (thirty grains to \mathfrak{z} i.) will effectually subdue the itching.

The various preparations of tar which have a deservedly high reputation as antipruritics may be used either in solution or in the form of ointments. One of the best antipruritic ointments is one drachm each of camphor and chloral to the ounce of ung. aq. rosæ. Another preparation which I have found of great service in allaying itching is the following: \mathfrak{R} Sodæ bicarb., \mathfrak{z} ij.; potassæ bicarb., \mathfrak{z} i.; glycerinæ, \mathfrak{z} ij.; tinct. opii, \mathfrak{z} iss.; aq., ad \mathfrak{z} viij. M.

The same preparation does not prove of equal efficacy in all cases, and when one fails, another may be found more serviceable.

Some of our Western confrères who have had a large experience in the treatment of this distressing affection may be able to give our correspondent therapeutic hints of more value.

EDITOR JOURNAL OF CUTANEOUS AND VENEREAL DISEASES.

BROWN DISCOLORATION FROM REPEATED EXPOSURE TO SULPHUR-VAPOR INSTANTLY REMOVED BY HYDROGEN PEROXIDE.

To the Editor of the Journal of Cutaneous and Venereal Diseases.

DEAR SIR :—During April, 1886, Mr. X—, aged 21, came under treatment for scabies. Several years before he had contracted syphilis, and had been under specific treatment for a good part of the time since. Between his first and second visits he had drank heavily, neglecting treatment for his scabies, and ending his spree only upon the supervention of a series of epileptiform convulsions, the first he ever experienced. He was put upon sulphur ointment and sulphur baths, and, as he improved rapidly, and was especially anxious to be free from the disease at the earliest possible moment, he took a sulphur bath every other day, half a pound at a time. When virtually free from the scabies, and looking forward to an immediate return to his home in the country (he had taken some four or five baths), his hands suddenly assumed a deep brownish color, and while the tint deepened, it also extended up the arms. The bath-keeper told him it was a common occurrence; that there was no help for it; it would wear off in a fortnight, etc. This bath-keeper had been thirteen years at his business, and spoke so authoritatively that Mr. X— was much chagrined; still he besought me earnestly to try and remove it. After some simple measures, which produced not the slightest effect, I ordered him to apply hydrogen peroxide. First giving the parts a soaking with hot water and soap, he applied the H_2O_2 with a tooth brush, and had the satisfaction of seeing the stain disappear completely in a single application.

EDWARD PREBLE, M.D.

4 EAST 37TH STREET.

TREATMENT OF RHUS POISONING.

HURON, OHIO, June 7, 1886.

Prince A. Morrow, M.D.

DEAR DOCTOR :—I notice in the June number of your JOURNAL OF CUTANEOUS AND VENEREAL DISEASES various remedies given by you for the treatment of poisoning by *Rhus toxicodendron*. I have tried some of them formerly, but of late years I use lime-water and olive-oil in equal proportions, with a little carbolic acid, and I find this does better than anything I have tried yet.

Thinking this might be of interest to your correspondent, I venture to mention it.

Faternally yours,

J. P. ESCH, M.D.

REMEDIES FOR RHUS POISONING.

NEW YORK, June 12, 1886.

Dr. P. A. Morrow, Editor Journal of Cutaneous and Venereal Diseases.

MY DEAR DOCTOR :—In the June number of your very valuable JOURNAL I noticed a request by Dr. Tompkins, of West Virginia, that you give a reliable remedy for the treatment of the poisoning resulting from the *Rhus toxicodendron*. I observed that you supplied the request most ably and fully, but I beg you will permit me to offer one suggestion upon the subject.

Carbolized vaseline with cocaine will prove, I think, one of the very best dressings for the relief of the distressing burning and itching which is always present in these cases. The dermatitis resulting from the poisoning has been treated by me both with a solution and an ointment, at different times, made

after the following formulæ, with the most gratifying results, affording positive relief to the patient while under treatment :

R. Acid carbolic (crystals)..... ℥ 20.
 Glycerite of cocaine, 4 per cent..... 3 ij.
 Vaseline..... 3 i.

M. Sig. Ointment.

R. Acid carbolic (crystals)..... 3 ss.
 Glycerite of cocaine, 4 per cent..... 3 iv.
 Aq. Laurocerasi..... 3 i.
 Aq. Rosæ..... 3 ij.

M. Sig. Lotion.

Either to be applied several times daily.

Respectfully yours,

J. BLAKE WHITE, M.D.

941 MADISON AVENUE.

DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

Scleroderma.

Dr. Radcliffe Crocker has published two excellent "Clinical Lectures on Scleroderma" (*Lancet*, Jan. 31, p. 191; Feb. 7, p. 237; May 23, p. 927, and May 30, p. 975). He describes diffuse symmetrical scleroderma by an account of four cases, of which three occurred in women. The first two cases are instanced as examples of the hypertrophic form of the disease, while the latter two were characterized by an atrophic condition of the affected skin, which he looks upon as probably a later stage of the pathological process in the majority of cases. He points out the frequent association of scleroderma with rheumatism and heart disease, but is disposed to believe that this is due to exposure to cold and wet in both cases, rather than to any special arthritic proclivity; in one patient subcutaneous nodules were found which exactly resembled in character and distribution those described by Drs. Barlow and Warner as rheumatic. The treatment recommended consists in good food and protection from changes of temperature, with ferruginous and other tonics and cod-liver oil. Shampooing after Turkish baths is also recommended, and treatment by galvanism receives mention. Dr. Crocker then passes to the consideration of the circumscribed form of the disease, to which the name *morphea* is commonly applied in England; he describes several cases, including a few in which the patches seem to have followed injury or friction by the clothes, and points out that the disease is not invariably distributed in the apparent course of nerves. A good account (illustrated by woodcuts) is given of the histological changes met with, and lastly, treatment is spoken of. This is unsatisfactory, as no internal remedy can influence the disease directly, and, he thinks, no local treatment has any good effect, but "any irritating application does harm, both in spreading and increasing the thickness of the patch." He thinks that galvanism of the neighboring skin might be tried, but would not recommend it over the patch itself; fortunately, however, recovery nearly always takes place in the natural course of the affection, although it may take many years. The lectures conclude with a description of the diffuse unsymmetrical form, which is of interest as forming a connecting link between the other two. The subject of "Scleroderma in Relation to *Filaria Sanguinis Hominis*" is treated of in a short communication by Dr. Bancroft (*Lancet*, Feb. 28, p. 380). He describes a case occurring in a young girl in Australia, and characteristically affecting the upper parts of the body, in which filariæ were frequently found in

the blood in large numbers. Dr. Finlayson has written "On the Occurrence of Symmetrical Gangrene of the Extremities in a Case of Scleroderma Adultorum" (*Med. Chronicle*, January, p. 315). The coincidence of these remarkable affections had already attracted the attention of Dr. Favier in France some years ago. A paper on "Diffuse Scleroderma," by Dr. Handford (*Lancet*, Sep. 26, p. 569), must also be mentioned. He gives a very full description of a case occurring in a girl at the unusually early age of 13.

Rhinoscleroma.

At the meeting of the Pathological Society on March 3, Dr. Payne and Dr. Semon showed drawings and microscopical specimens from a case of this rare disease. The patient was a Guatemalan, aged 18; the disease had existed four years, and had begun insiduously, without known cause. There were two rounded reddish swellings, firm but not very hard, each about the size of half a hazelnut, and ulcerated on the surface, just below the nostrils, both of which were filled with similar masses. The bridge of the nose was considerably broader than normal, and the tissues of the nose beyond the bones were of stony hardness to the touch. The throat was also affected; the uvula had entirely disappeared, while on the soft palate an irregular, raised, whitish, slightly ulcerated patch was seen. The rest of the soft palate had undergone considerable cicatricial contraction, fibrous bands running from the ulcerated patch in all directions. Energetic antisyphilitic treatment was continued for some months, but with no result; the case was therefore treated by operation, the external tumors and the masses blocking the nostrils being thoroughly scraped out with the sharp spoon, and the exposed surface freely cauterized. In spite of these precautions, unmistakable signs of recurrence made their appearance two months afterwards. The whole histological structure was quite different from epithelioma, or sarcoma, or any other definite tumor-formation, but rather resembled the "granulation" tumors, such as lupus, syphilis, etc., though quite distinct from any of these. This patient had previously been in Paris, and while there, M. Cornil had an opportunity of examining the growth for micro-organisms; these were not at first detected; later, however, they were found, and Dr. Payne was able to demonstrate them at a later meeting of the Society. "A Further Note on Rhinoscleroma," by Dr. Morell Mackenzie (*Brit. Med. Journal*, March 21, p. 587) refers to the same patient, who was for some time under his care.

Multiple Xanthoma.

A somewhat anomalous case of this rare affection is reported by Dr. Kent Spender (*Brit. Med. Journal*, March 7, p. 482). A lady, aged 30, was completely crippled by "chronic osteo-arthritis," which had existed about six years. About a year before she was seen, the skin of the soles began to grow yellow, and a year later brownish-yellow spots and patches, from one-eighth to one-fourth of an inch in diameter, appeared on the upper and front part of the right leg. The spots felt slightly raised. Subsequently the palms of the hands became tinted yellow, like the soles, and this color gradually became deeper and extended in area; it appears to have been diffused. As Dr. Spender says that "the nails of the left thumb and right great toe have separated from their respective phalanges, and are almost torn from the matrix by an increasing accumulation of dry chalky material," it would seem that true gout was to some extent responsible for the patient's condition. There had never been jaundice nor any other disorder of the liver, and the urine contained neither albumin nor sugar.

Ringworm.

Dr. Foulis considers 'the following' an effectual plan of treatment in ringworm of the scalp (*Brit. Med. Journal*, March 14, p. 536). The affected child, the hair being cut short over and around the affected parts, is seated before a basin half filled with warm water, and a folded towel tied round the forehead, so that no fluid poured on the head can trickle into the eyes. The child bends forward over the basin, and spirit of turpentine is freely poured over one or more spots at a time, and well rubbed into the scalp with the forefinger. This removes dirt and greasy scabs, and the short broken hairs are seen to stand up like bristles. In about three minutes smarting is complained of, showing that the turpentine has penetrated deeply. Carbolic soap is then immediately well rubbed in and made to lather by the warm water, the smarting soon subsides, and the head, being now beautifully clean, is dried. Compound tincture of iron, in two or three coats, is now painted well over the affected parts, and allowed to dry. Carbolic oil (1 in 20) is then rubbed into the rest of the hair when it is dry. This treatment, applied every morning, or morning and night in severe cases, generally cures the worst cases in the course of the week. (It is this method which has been found unsuccessful by Dr. Hallopeau and Laller in Paris. See this JOURNAL, February, p. 50. Dr. Foulis' name is misprinted 'Fontis.') Dr. Henry Browne (*Brit. Med. Journal*, June 6, 1885, p. 1,153) gives the following formula as having yielded perfectly satisfactory results. \mathcal{R} Sodæ hyposulphitis \mathfrak{z} i., solve in aquæ fl. \mathfrak{z} viij., et adde acidi hydrochlorici fl. \mathfrak{z} i., for outward use only. The lotion is applied on lint covered with oiled silk, and accompanied by daily washing of the scalp with soft soap and water. Dr. A. I. Harrison communicated a paper on "A New Method of Treating Tinea Tonsurans" to the section of medicine at the last meeting of the British Medical Association (*Brit. Med. Journal*, September 5, 1885), and published a note giving further explanations (*Brit. Med. Journal*, December 5, 1885, p. 1,059). This treatment, as finally modified, consists in the application, by dabbing on the scalp, of a solution of half a drachm of iodide of potassium to the ounce of a mixture of equal parts of liquor potassæ and spirits of wine, for three or four minutes at a time. When this has been done two or three times at intervals of two or three days, a solution of four grains of bichloride of mercury to the ounce of a mixture of equal parts of distilled water and spirit of wine is applied in the same manner, and on the first occasion ten minutes after the use of the potash and iodide lotion; afterwards it is used by itself two or three times at two days' interval. A few days are then allowed to elapse without the application of any remedy, and then the potash solution is applied once, and followed up with the mercurial solution at an interval of ten minutes. Dr. Harrison has treated many cases in this way with good results, and claims great penetration for the remedy, as the hairs are much softened by the potash, while the mercury is precipitated *in situ* by the iodide of potassium, and thus brought into immediate contact with the fungus in the hair-follicles.

Syphilis.

In syphilis, we are fortunate in having several lectures from Mr. Jonathan Hutchinson. One is entitled "On Chancres and Syphilis, an elementary lecture addressed to students" (*Med. Times and Gazette*, March 21, 1885, p. 373, and March 28, p. 405). Although this is called elementary, it is full of interesting and instructive matter; as is also his lecture on "Herpes and the Recurrent Chancre, also on the Intermediate Period of Syphilis" (*Med. Press*, October 28, p. 391), but his

"Lettsomian Lectures on some moot Points in the Natural History of Syphilis, delivered before the Medical Society of London" early in the present year, may be considered as among the most suggestive and remarkable contributions which have appeared in recent times. It is not possible to abstract these lectures; they are reported in full in the *British Medical Journal*, January 9, 1886, p. 55, January 23, p. 141, February 6, p. 239, and February 13, p. 279, and will probably soon be republished in book form. Dr. Myrtle's "Clinical Remarks on Secondary Syphilis" (*Med. Press*, April 22, 1885, p. 343) give details of some interesting cases.

JOHN CAVAFY.

LONDON.

Selections.

INFLUENCE OF MERCURY IN DELAYING SYMPTOMS AND AS AN ANTIDOTE IN SYPHILIS.

MANY of the diseases just mentioned (rupia, psoriasis palmaris, syphilitic lupus, periostitis, symmetrical nerve affections) would probably occur much earlier in the evolution of constitutional syphilis, and would be recognized much more definitely as belonging to the secondary stage, were it not for the almost constant employment of antidotal specifics. The effect of mercury, when it does not absolutely cure, is usually to delay and retard. In many cases, the patient remains free from symptoms so long as he continues the drug, but experiences an outbreak within a few weeks or a few months after suspending its use. It seems to be quite easy, if mercury be begun on account of the primary sore, and well antecedent to the appearance of any secondary symptoms, to entirely prevent the development of the latter. I have witnessed this prevention over and over again, and it appears to be the rule, rather than the exception, that no secondaries should appear. The immunity, however, not unfrequently lasts only so long as the drug is continued, and within a few weeks after its omission, even when the course has been one of six or eight months, a rash on the skin will show itself. Thus it may easily be the fact that inflammations of the eye and ear, and of other parts of the nervous system, which occur, in the natural course of things, later than skin affections, may be yet further retarded by treatment, and may sometimes appear almost to encroach upon the tertiary period, although definitely belonging to the secondary.

Influence of Mercury as an Antidote.

Among the questions which may fairly be considered as moot points in the natural history of syphilis, we may count those which concern its relation to the specifics used in its treatment. The claim of mercury to rank as an antidote to the virus of syphilis, has, I think, been much strengthened by the results of recent experience, and it is one of extreme importance in reference to a very important department of general pathology and therapeutics. In connection with it, we may suitably bear in mind the great repute which weak solutions of corrosive sublimate have recently obtained in the prevention of septic processes in wounds. In former times, when mercury was given in large doses, and allowed to produce violent effects, and when, of necessity, its administration was frequently interrupted, the development of constitutional symptoms in some form or other was so constant, that much hesitation was felt by all as to the use of

such a word as "antidote." Of late years, we have got into the habit of using only small doses, and giving them over very long periods, carefully taking every precaution against the necessity for interrupting them. I will ask permission to state briefly my own rules of practice, and the impressions which I have formed as to results. As those impressions have been formed for many years chiefly in private practice, and amongst patients concerning whom I have often had opportunities for obtaining information over long periods, I am in a position to speak with much more confidence as to results than would otherwise have been the case. The remedy which I have used almost exclusively has been the gray powder, and the dose usually not more than a single grain. This dose I have given from three to six times in the course of twenty-four hours, according to circumstances, and seldom for a shorter course than six months in the first instance. If this dose be given to a patient with an indurated sore, but in whom, as yet, no secondary symptoms have appeared, the result will usually be that none will occur. If the rash have already made its appearance before the treatment is commenced, as a rule it quickly fades, and so long as the patient continues the remedy he remains free. The exceptions to completeness of freedom concern chiefly the mouth and the throat.

It is very seldom indeed that there is any difficulty in keeping the skin perfectly clear. In the tonsils, and sometimes in other parts of the lining membrane of the mouth, sores will occasionally form; and, although these are in a general way amenable to an increase of the dose, and to the local use of the drug (as a black-wash gargle), it is to be admitted that there do occur occasionally cases in which it is difficult to be sure that the supposed remedy does not aggravate the disease. In a large majority of cases, however, in which, beginning at an early period, the patient is put under a six months' course, during the last four of this period, he is absolutely without symptoms, and apparently in excellent health. If, however, at the end of this time, the remedy be stopped, in many cases a very remarkable proof of its antidotal efficacy will occur. We shall find that it was it, and it alone, which had held the poison in inactivity. For, in spite of the long period of absolute quiescence, an outbreak of symptoms will occur within a few weeks of its suspension. This outbreak is usually a very mild one, but is, nevertheless, very definite, and it is general. It usually takes the form of an erythematous or lichenoid eruption, occurring chiefly on the trunk, and is not often attended by sore-throat or other symptoms. Although it may now and then be papular, I have never seen it approach in severity the eruptions which we often see in cases which have not been treated. In more than one case, I have known this eruption which comes after the suspension of mercury mistaken for scarlatina. It is always, I believe, very easily amenable to mercury, disappearing in the course of a few days, or at most a week or two, and seldom recurring. There is, however, another very peculiar eruption which sometimes persists for a long time, and recurs over and over again. I have been in the habit of speaking of this as "after-bath eruption." It is a very trivial affair, and consists chiefly in the appearance of a number of faintly marked erythematous rings, which are seen only on sudden exposure of the body to cold, as on first getting out of bed, and especially after the use of the morning bath. Nine out of ten patients notice them only under the latter condition, and they generally fade away almost completely after a few hours. These rings are seen most frequently on the arms, but sometimes on the trunk and thighs. They are unquestionably syphilitic, and the liability to them usually ceases on the recurrence to mercurial treatment. They are seldom or never attended by other manifestations of the disease.

Respecting the results of treatment in general, I believe I may with truth assert that I have never, in any single case of late years, seen a severe eruption of the skin develop itself after a mercurial course of the kind indicated had been commenced. It is a fact, then, that the remedy manifests antidotal power in that it cannot only remove, but anticipate and prevent, by far the most conspicuous manifestations of the disease. I cannot make so strong an assertion respecting some other of the symptoms of the later part of the secondary stage. I have seen iritis and neuro-retinitis occur occasionally, with even some severity, in cases which had been well treated, and, in very exceptional instances, I have witnessed disease of the arteries of the brain. In a large majority of cases, however, a six months' course of small doses appears to be adequate to the complete and permanent cure of the disease. No relapses occur, and the patient remains afterwards in excellent health.

We may admit that it is a question which must be left open for future accumulations of evidence, whether the antidotal repression of the secondary stage is influential in preventing the development after a long interval of tertiary symptoms. That it does not do so always is abundantly proved. I cannot but believe, however, that it does exercise a very powerful influence in that direction, and that the diminishing frequency and severity of tertiary disease in modern times is largely due to better regulated treatment. It is often matter of remark that those who do suffer seriously after long intervals, are those in whom the early symptoms were exceptionally slight, and treatment in consequence not persevered with, or almost wholly omitted.

In urging the antidotal efficacy of mercury as a fact in the natural history of syphilis, I have not in the least wished to claim superiority for the special mode of administration which I have mentioned. I do not doubt in the least that the advocates of other methods, such as those by inunction or by the vapor-bath, can produce just as good results. The essential point seems to be that the treatment should be very long continued, or, if not, that short courses should be repeated without waiting for symptoms. The method which I have advocated is simply one of the most convenient.—Extract from a lecture by J. HUTCHINSON, *British Medical Journal*.

EXCORIATIONES NARIUM.

In the *Monatschrift für Ohrenheilkunde*, etc., No. 7, 1885, there appears an article bearing the above title, and written by my friend Dr. Schmiegelow, of Copenhagen. Having recently had some cases of the troublesome affection which he describes under my care, in which the ulceration in the outer part of the nostril was progressing, and showed no sign of healing until treated with anti-bacterial agents, such as carbolic acid lotion, iodoform, etc., I think that the following conclusions which Dr. Schmiegelow has come to, and which I share, are of interest:

1. The term *Eczema narium*, which is sometimes applied to the affection, is misleading, because it only represents the less important and not constant accompaniment of the disease, which is really in the large majority of cases a furunculosis of the sebaceous glands which are connected with the vibrissæ in the nostril. Further, Moldenhauer concludes that the few cases in which there is no furunculosis, and where the affection is a pure eczema, are those of scrofulous children, or of adults where it is an extension of a facial eczema to the nostril.

2. Pasteur and Löwenburg have found a great many micrococci in the pus of a furuncle, and believe that the latter is caused by bacterial affection.

3. Every cause of solution of continuity of the epidermis may produce furuncle, by creating a nidus for the deposit and increase of micrococci, and through their agency inflammation of the sebaceous glands is set up. As chronic eczema of the external auditory meatus is the cause of furuncle in that situation, so eczema of the entrance to the nostril causes furuncle of the nasal cavity, since the patients thus affected, by removing the small scabs that form, produce solution of continuity of the epidermis, by rubbing the part in order to allay the irritation which is present, pull out small hairs, and thus allow of the possibility of micrococci getting into the sebaceous glands and inflaming them.

4. Individuals having numerous stiff vibrissæ in their nostrils are more predisposed to "excoriationes narium" than those who have a few short soft hairs, because the nasal secretion is not collected by the latter to so great an extent as by the former, and therefore scabs are not so readily produced.

5. The affection is most obstinate if it attack the region between the ala and septum nasi, as here there is more chance of stagnation of the nasal secretion, and more difficulty in removing the crusts that form.

6. The aims of treatment are:

1. To prevent the formation and increase of scabs.
2. To protect the epidermis from further solution of continuity.
3. To sterilize the nostril.

7. Epilation is irrational, as it only leads to the opening of new orifices hitherto closed by the hairs, into which micrococci find their way, and by multiplying form abscesses. Baumgarten also denounces this method of treatment. Also the old-fashioned treatment, by means of ointments, glycerin inunctions, and application of nitrate of silver, are all untrustworthy, if not worse.

8. The treatment to be recommended is the following: Small pieces of cotton wool are soaked in an aqueous solution of corrosive sublimate of the strength of 1 to 1,000, or, if this is irritating, of 1 to 2,000. The tampons must be of such a size as to quite fill the nostril, and one nostril at a time is to be filled with its tampon, which must be allowed to remain in it for two hours, then removed, and the other, if affected, operated on. This must be done two or three times daily at first; later on, one tampon a day for each nostril may be sufficient. If irritation is set up by the HgCl_2 it should be omitted for a few days, and an ointment, composed of one part of boracic acid to 10 of vaseline, used instead; the use of HgCl_2 being resumed when the irritability is allayed. Treated in this way, no new crusts form, the patients do not "pick their noses" and thus increase the area of infection, and the part acted on is sterilized.

9. This treatment has proved most successful in more than forty cases, the cure being absolute in nearly all in the course of a fortnight. If the affection shows any tendency to recur, washing with the weaker solution of HgCl_2 is sufficient to prevent it.

10. Where scrofulous children are affected with nasal excoriation, which is often of doubtfully parasitic origin, Kisselbach recommends the application of tampons which are soaked in a diachylon and petroleum ointment, as the use of HgCl_2 for these patients is usually too irritating.

Dr. Schmiegelow has given up the use of the stick of nitrate of silver for these nasal ulcers, and so have I. I may add that in syphilitic and tubercular ulcers of the tongue I have found that the use of a saturated solution of iodoform in ether is very valuable. Numerous cases under my care in which these ulcers had been treated for months by solid caustic, with no effect excepting irritation of the part, yielded to the iodoform treatment, the healing process beginning very soon,

and the patients complaining of much less pain after its use. I tell the patients to rinse the mouth with cold water after each meal, and then paint on or spray on to the ulcer some of the iodoform solution, when the iodoform is left in very fine powder on the ulcerated surface.—DR. BARON, *Bristol Medico-Chirurgical Journal*, March, 1886.

CHRYSOPHANIC CONJUNCTIVITIS.

THAT the application of chrysophanic acid to the integument is sometimes followed by a disagreeable conjunctivitis has long been recognized as constituting one of the chief objections to its use. This objectionable result was most frequently observed after its application in the form of an ointment to the integument of the head and face, and was supposed to be due to an irritant action from direct contact. It was sought to be corrected by the substitution of pyrogallie acid or the oil of cade in the treatment of psoriasis affecting these regions. The general use of the chrysophanic acid in the form of fixed adhesive dressings, in combination with collodion, gelatin, or traumaticine, was also thought to have diminished the danger of its occurrence.

Dr. Trousseau (*Annales de Dermatol. et de Syphilig.*, May 25, 1886) has made a special study of chrysophanic conjunctivitis. According to this authority, it occurs in from four to fifty per cent of all patients treated with the traumaticine combination. He also asserts that the application of chrysarobin to the trunk and lower extremities is just as likely to provoke a conjunctivitis as when applied directly to the face.

The clinical features of chrysophanic conjunctivitis are thus described. During the night following the painting with the traumaticine, the patient is awakened with a sharp, smarting pain in one eye; there is a pricking sensation as if sand were in the eye. The next day, the pain is markedly increased; there exists blepharospasm and intense lachrymation, sometimes a slight degree of photophobia; the conjunctiva is injected, but there is no trace of conjunctival secretion and the cornea is normal. This affection then makes its debut brusquely, as a rule from twelve to twenty-four hours after the application; it is almost always double, one eye is affected, and some hours later the other eye becomes inflamed. In one case, three days elapsed before the second eye became affected. When the affection is established, besides the symptoms of pain and irritation just mentioned, the bulbar conjunctiva becomes quite red and vascular; the palpebral conjunctiva presents the same aspect, especially the inferior palpebral conjunctiva. It sometimes happens that the superior palpebral participates but slightly in the inflammatory process; in this case it was not involved.

The duration of the acute stage is three or four days; the pain, the lachrymation, and the blepharospasm begin to subside on the third day; the injection persists longer, especially over the globe and in the inferior cul-de-sac. All the phenomena disappear at the end of eight or ten days without treatment. The symptoms may be alleviated and the duration of the disease abridged by the continuous application of compresses dipped in lukewarm borated water (four per cent). The fact is insisted upon that there is an absence of conjunctival secretion; sometimes the eyelids may be glued together upon awakening in the morning.

The author devotes some interesting study to the question whether the conjunctivitis is due to a direct inoculation of the chrysophanic acid by the intermediary of the fingers, or whether it is a manifestation of a general intoxication

by the acid, consecutive to its absorption by the cutaneous surface. He made some experiments upon the eyes of rabbits, introducing a small quantity of the solution. In all of the twelve rabbits experimented upon, there was provoked a muco-purulent or frankly purulent secretion. The patients who touched their eyes with their fingers soiled with the chrysophanic solution presented a conjunctivitis with secretion.

He concludes that chrysophanic conjunctivitis, characterized by dryness or absence of secretion, is due to absorption of the medicament, and not to direct contact, at the same time admitting that more complete studies are necessary before the question can be regarded as definitely settled.

TREATMENT OF PIGMENT SPOTS OF THE SKIN.

ACCORDING to Unna, borax and the bichloride of mercury are the medicaments must generally employed for the removal of pigment spots; the first is slow and mild in its action, rarely occasioning eczema; the second acts more energetically and rapidly.

If we desire to have the speediest possible effect, it is necessary to have recourse to mercury, not in the form prescribed by Hebra, which is inconvenient, but a solution of the sublimate in collodion (one-half to one part). The danger will thus be avoided of provoking redness, desquamation, and sometimes even a bullous eruption.

These energetic treatments have one inconvenience: we cannot exactly measure the effect. On this account, it is preferable to employ the mercury and bismuth ointment proposed by Hebra. A piece of muslin coated with the ointment will enable us to obtain a more prompt effect than with feeble solutions, besides being much more convenient of application.

Small pieces of muslin, about the dimensions of the groups of freckles or chloasmic spots, should be smeared with the ointment, and after first removing the greasy matter from the surface with cologne or alcohol, they should be applied to the affected parts. The application should be made upon the patient's retiring at night, and washed off the next morning. Bandaging or collodion is unnecessary.

The author prescribes for use during the day a bismuth ointment, which has the advantage of masking the brown spots.

The following is the formula of the ointment:

R Oxide of Bismuth,	
Kaolin.....	5 grams.
Vaseline.....	20-40 "
M.	

The ointment should be applied only to the pigmented spots, allowed to dry and not be removed for some time.

He also employs the following formula:

R Oxide of Bismuth,	
Rice Powder.....	2 grams.
Ung. Glycerinæ.....	10 "
Eau de Rose.....	20 gutt.
M.	

By alternating the mercurial and bismuth applications, the pigment patches rapidly disappear without redness or desquamation, if the pigment be not so

deeply situated in the derma that the remedies cannot reach it without destroying the papillary layer, as is the case in certain chronic chloasmas.

The following is Hebra's formula:

℞ Subnitrate of Bismuth,
White Precipitate..... āā 2 gr. 50
Lard..... 50 grams.

M.

To be spread upon a piece of lint, and applied during the night to the pigmented patch.

Kaposi employs the following ointment in the same manner.

℞ Salicylic Acid..... 2 grams.
Emollient Ointment..... 40 “

M.

Or,

℞ Boracic Acid,
White Wax..... āā 5 grams.
Paraffin..... 10 “
Oil of Almonds..... 30 “

M.

Frictions with the ordinary mercurial ointment sometimes succeed well.—*Jour. de Méd. de Paris*, No. XV., 1886.

ERUPTION OF HERPES ZOSTER DURING THE EMPLOYMENT OF ARSENIC.

In connection with a few cases of zoster appearing after the prolonged use of arsenic, which were already known to the profession, Dr. Julius Burger (*Vierteljahrschr. f. Dermat. und Syphilis*) reports three new instances in which, after several months' use of arsenic, typical unilateral zoster appeared along the course of the intercostal nerves.

In spite of a continuation of the arsenic, no relapse occurred after the healing of the first eruption. The author is not fully convinced of the dependence of the zoster upon the arsenic. It is not plainly to be seen how a single nerve should be altered by the arsenic. Again, in his cases, all symptoms and appearances of arsenical poisoning were absent, and finally the absence of recurrence of the disease in spite of a continued use of the drug led the author to believe in an accidental coincidence.—*Wiener Med. Wochens.*, No. 9, 1886.

ANÆSTHESIA OF THE SKIN FROM MERCURIAL POISONING.

HYPERÆSTHESIA of the skin as a result of mercurial poisoning has been recognized as the effect of the drug upon the sensory nervous system.

Freney has recently reported a case in the *Gazette des Hôpitaux* in which the very opposite effect was noted, viz.: anæsthesia. A workman in a mirror factory, presenting all the symptoms of mercurial poisoning, showed anæsthesia of the whole body, which was more marked on the right side. Thermal sensibility was suspended also on this side and in both lower extremities. Analgesia was observed in regions where tactile and thermal sensibility was not entirely abolished.

After the use of iodide of potassium and sulphur baths, these symptoms entirely disappeared.

Editorial.

ARSENIC IN SKIN DISEASES.

THE claim that arsenic is the most valuable remedy we possess in the treatment of diseases of the skin has been so long accepted as an established therapeutical fact, that any question of its superior efficacy may appear like downright heresy. Arsenic is not only reputed to possess specific virtues in certain forms of skin affection, but it has been accredited with a wide range of therapeutic action, and has been recommended in so many diseases which have no etiological or pathological relationship, that it has come to be considered by many as a sort of panacea for all cutaneous disorders. Certainly no other drug has been so universally employed, and in so large a variety of morbid conditions of the skin.

Whether the reputation of arsenic as a remedy in skin diseases rests upon a basis of sufficiently careful clinical experience is a proper subject for inquiry.

The universality of its employment cannot be accepted as affording positive proof of its therapeutic worth. The history of medicine records many drugs which, after enjoying a more or less extended reign of professional favor, have been relegated to the limbo of forgotten or disused remedies. We do not wish to be understood as intimating that a similar experience is likely to befall the drug now under consideration, but we think it exceedingly improbable that it will always continue to hold the high place it has occupied in cutaneous therapeutics. For a number of years we have regarded arsenic as a very much overrated drug, and while we recognize its undoubted efficacy in a limited number of chronic inflammatory disorders, we believe that the range of its judicious application is comparatively restricted.

We are glad to find ourselves so nearly in accord with the views embodied in Dr. Fox's propositions, published in the last number of this JOURNAL, respecting the value of arsenic in skin diseases. Especially would we join in his protest against the "practice of giving arsenic in nearly every case of skin disease as irrational and harmful." A full and free discussion of these important propositions cannot fail to be of the

greatest practical interest, both to the specialist and the general practitioner.

We had hoped to present in this number the views of the members of the New York Dermatological Society upon these points, but, unfortunately, the discussion was postponed until a future meeting. While the majority of physicians will probably not yield unqualified approval to Dr. Fox's somewhat sweeping denunciation of arsenic, yet we think all will agree that its routine administration in cases where there are no rational indications for its use is to be condemned.

That arsenic, perhaps more than any other drug, exercises a positive and direct influence upon the nutrition of the skin cannot be questioned. There is scarcely any form of eruptive disturbance which may not be provoked by its internal use. A reference to the article on "Arsenical Eruptions" in the present number shows how wide is the range of its pathogenetic influence.

The fact that arsenic is capable of producing such a marked and decided impression upon the skin has been held as an argument for its efficacy as a remedy in diseases of this organ, on the principle that the more powerful the poison the more potent the remedy. This principle cannot, however, be accepted as a safe guide in determining the therapeutical value of the drugs employed in dermatological practice. Bromide of potassium, for example, produces eruptive disorders of the most severe and varied character, yet it does not play an important rôle in cutaneous therapeutics. The dermatopathic influence of iodide of potassium is as pronounced, perhaps, as that of arsenic, yet its value is recognized in only a single class of eruptions. The same may be said of quinine and many other drugs capable of causing a morbid determination toward the cutaneous surface. The study of the physiological and toxic effects of a drug does not always afford correct indications as to its remedial action. Upon this point conclusions of practical value can be gained only by careful and extended clinical observation.

With the view of collecting and comparing the results of the experience of a large number of physicians, we would request each of our readers to furnish us information upon the following points :

Are you in the habit of employing arsenic, *generally*, in the treatment of diseases of the skin ?

In what forms of skin disease have you found arsenic of superior value to other remedies ?

What ill effects, if any, have you observed from its use ?

What preparation of arsenic do you prefer, and in what doses do you employ it ? Address:

EDITOR OF JOURNAL OF CUTANEOUS AND VENEREAL DISEASES,
66 West 40th street, New York.

Reviews.

LEHRBUCH DER HAUT- UND GESCHLECHTS-KRANKHEITEN, für Studirende und Aerzte. Von DR. EDMUND LESSER. Zweiter Theil. Geschlechts-Krankheiten. Leipzig : Verlag von F. C. W. Vogel, 1886.

The first part of this work, relating to diseases of the skin, was favorably noticed in a previous number of this JOURNAL. The second part is devoted exclusively to the consideration of venereal diseases. It may be a question whether skin and venereal diseases are sufficiently related to justify their forming component parts of the same treatise. Certainly, from a general standpoint, the group of affections, comprehended under the general term venereal diseases, is entirely distinct, but since the principal phenomena of the most important member of this group—syphilis—are manifested upon the skin, its nosological position has naturally been placed among diseases of the skin. From a clinical point of view, however, the separation of dermato-syphilis from the ordinary dermatoses is not practicable, as they are constantly brought into close association for purposes of differential diagnosis.

As in the preceding volume, the author aims to give a clear and concise exposition of our knowledge of the subject, sufficiently comprehensive to embrace all essential points, without being too diffuse or exhaustive for the wants of the student. His description of the different diseases, their symptoms, complications, and treatment is to be commended for its simplicity, accuracy, and brevity. The author accepts as an established fact the bacterian origin and nature of venereal diseases. He recognizes the gonococcus of gonorrhœa and the bacillus of syphilis as the sole pathogenetic factors in the causation of these diseases ; the microbian origin of chancreoid he regards as in the highest degree probable, though not definitely proven.

Although he is a firm believer in the parasitic origin of gonorrhœa, we do not perceive that anti-parasitic treatment figures prominently in his means of cure. His assertion that non-specific urethritis is distinguished by its short duration and spontaneous cessation is open to question. On the contrary, it is often found that a urethritis, dependent upon other causes than contagion, may be characterized by prolonged persistence and obstinacy to treatment.

In the treatment of primary syphilis, the author strongly recommends the excision of the chancre as an abortive measure. He says, " the primary affection is in all cases to be excised, when its localization admits of the operation, and when too long a time has not elapsed since infection." In the general treatment of syphilis he regards mercurial inunctions as the most promptly efficacious of all

methods of employing the drug. He describes in detail the technique of subcutaneous injections, and reviews the list of mercurial preparations which have been recommended for this purpose. Due consideration is also given to the local treatment of syphilitic lesions.

DE LA SARCOMATOSE CUTANÉE. Par Le Docteur LEON PERRIN, Ancien Interne en Médecine et en Chirurgie des Hôpitaux de Paris. Paris: G. Steinheil, Editeur, 1886.

This monograph of nearly 300 pages, which forms the inaugural thesis of Dr. Perrin, must be regarded as a most valuable contribution to medical science.

The tumors of the skin embraced under the general term "sarcoma," though comparatively rare, are of great clinical importance, yet they are mentioned only in the more recent text-books on dermatology and, indeed, their very existence as a distinct class of neoplasms was not recognized until a few years ago.

The literature of cutaneous sarcomata has been embodied principally in observations scattered here and there in medical journals. The cases have been reported under a great diversity of titles, the observers themselves often being ignorant of the name and nature of the disease described. It is not surprising, therefore, that our knowledge of this important class of affections should be so vague and unsatisfactory. Dr. Perrin has attempted the difficult task of evolving order out of confusion by analyzing this mass of crude material, and reducing it to the proportions of scientific knowledge. His work is based upon the careful study of fifty-four cases of cutaneous sarcomata which he has found recorded, together with two cases which came under his personal observation during his internat at the St. Louis Hospital. These cases he has classified and arranged according to their histological and clinical characters and has given us a clear and intelligible description of the different varieties of sarcoma, with their typical and differential features. Some of these cases were not found to correspond with any of the recognized types of sarcoma and, in constructing his classification, he has traced new types of the disease.

The first chapter is devoted to an exposition of the views of different authorities as to the nature of sarcoma. He accepts the definition of Cornil and Ranvier, viz.: "Tumors constituted by pure embryonic tissue or undergoing one of the first modifications in its transformation into adult tissue."

Sarcomata of the skin are divided into two principal classes: 1st, *Melanotic* sarcomata; 2d, *Non-melanotic* sarcomata: the first constituting a group perfectly distinct, the second being subdivided into *primitive idiopathic* and *secondary metastatic*. The primitive idiopathic sarcomata may be either generalized or localized.

The mode of debut, the evolution, the objective characters, and the pathological anatomy of these different varieties are then considered in detail, together with their etiology, prognosis, and treatment. The lines of demarcation which separate true sarcomata from other cutaneous lesions presenting similar objective and clinical characters are clearly indicated.

A very interesting study is made of the relation existing between mycosis fungoides and generalized sarcomata—two diseases which are regarded by many authorities as identical. Our author believes in the distinct individuality of mycosis fungoides, while admitting that the mycosis group includes a variety of sarcoma which he denominates "primitive generalized sarcoma of a pseudo-mycotic form."

It is, of course, impossible, without entering into an extended analysis of the

work, to give more than an outline of its general character and scope. We cannot too highly commend the scientific spirit displayed in undertaking this difficult task, the painstaking labor expended in collecting and systematizing such a mass of material, and the intelligent judgment exercised in dealing with the difficult and obscure questions with which it is surrounded.

The work is enriched with an admirably executed chromo-lithograph, representing the histological characters of a generalized primitive non-melanotic sarcoma which the author personally studied.

THE PRINCIPLES AND PRACTICE OF MEDICINE. By the late CHARLES' HILTON FAGGE, M.D., F.R.C.P., Physician to and Lecturer on Pathology at Guy's Hospital, etc. Including: A Section on Cutaneous Diseases, by P. H. PYE-SMITH, M.D., F.R.C.P. Chapters on Cardiac Diseases, by SAMUEL WILKES, M.D., F.R.S. And Complete Indexes, by ROBERT EDMUND CARRINGTON, M.D. In Two Volumes. Philadelphia: P. Blakiston, Son & Co., 1886.

In the preparation of this Treatise on the Practice of Medicine, its late lamented author, we are informed, was constantly occupied the last twelve years of his life. It embodies the results of his laborious researches as a pathologist, and of his observations and experience as a clinician during the long term of years in which he was connected with Guy's Hospital. His position afforded almost unexampled opportunities for pathological and clinical study, and the result shows that he utilized the rich resources at his command to the best advantage.

The first impression one has of this work is its magnitude, and the truly cyclopedic character of its contents. Nearly 2,000 pages of solidly printed matter, relating to every subject in the domain of practical medicine, and embracing certain special departments not usually treated in a text-book on practice, is certainly a phenomenal production, even in the present age of prolific writers.

Dr. Fagge was peculiarly fitted for successfully carrying out so great an undertaking. Naturally endowed with a wonderfully retentive memory, a zealous worker, with trained habits of observation, and gifted with sound judgment and a genius for the generalization of clinical facts, he has produced a work which has been justly characterized as "a fuller, more original, and more elaborate text-book on medicine than has yet appeared." Upon every page we have evidence of original thought and independent investigation. It is perhaps, more than any other systematic treatise on medicine, a personal one—the outcome of the author's individual observation and experience.

The first volume treats of General Morbid Processes, Specific Diseases, Diseases of the Nervous System, and Diseases of the Respiratory Organs. The second volume is devoted to Diseases of the Heart, Diseases of the Digestive Organs, Liver, Spleen, and Kidneys, Diseases of the Bones, Joints and Blood, and Diseases of the Skin; concluding with copious indexes of authors and subjects, which will be found invaluable in facilitating ready reference. As an evidence of the exhaustive manner in which the different subjects are treated, we may instance the fact that 444 pages are devoted to diseases of the nervous system alone, forming in itself a complete and elaborate text-book on this important branch.

The section on Diseases of the Skin is the work of the editor, Dr. Pye-Smith. While from the American dermatological standpoint exceptions may be taken to certain peculiarities of nomenclature and classification, yet in the description of

the different diseases, their pathology and treatment, and all essential points relating to a knowledge of the subject, his work is to be commended, and has been brought up to the latest advances made in this department.

This work may, with peculiar propriety, be recommended to the readers of this JOURNAL, a majority of whom are general practitioners, since, in addition to its high value as a standard text-book on the Principles and Practice of Medicine, it presents the additional attraction of including a complete treatise on Diseases of the Skin.

Books and Pamphlets Received.

Die neueren Fortschritte in der Therapie der Hautkrankheiten, von P. G. UNNA, Hamburg. Reprint.

Die Bacillenkuppen der Leprahaut sind keine Zellen, von P. G. UNNA, Hamburg. Reprint.

Wo liegen die Leprabacillen? von P. G. UNNA, Hamburg. Reprint.

Erwiderung auf Unna's: Wo liegen die Leprabacillen? von DR. K. TOUTON. Reprint.

Zur Aetiologie der Alopecia Areata, von DR. MAX JOSEPH, Berlin. Reprint.

Die neueren Arbeiten über die spezifische Energie der Hautsinnesnerven, von DR. MAX JOSEPH, Berlin. Reprint.

Zur Casuistik des Lichen ruber planus der äusseren Haut und der Schleimhäute, von DR. A. J. PROSELOW. Reprint.

Storia di Idros-Adenite Neoplastica con relativo studio Theorico-clinico-anatomico, Altro Caso di Idros-adenite sifilitica. Pel PROF. CAV. PIETRO GAMBERINI.

Epididymitis Syphilitica. DR. KAROL SZADEK, Kieff, Russia. Reprint.

Lichen Planus Wilsonii. DR. K. SZADEK. Reprint.

Items.

ECZEMA OF THE HAIRY SCALP.—

R	Acidi Salicylici.....	8 gr.
	Spts. Mindereri.....	25 “
	Glycerinæ.....	100 “

M. —SCHWIMMER.

SCABIES.—

R	Naphthol,	
	Chalk,	
	Sulphur precip.	āā 10 gr.
	Lard.....	100 “

—SCHWIMMER.

EPIDIDYMITIS.—Painting with traumaticine.—SCHWIMMER.

ANNUAL MEETING OF THE NEW YORK DERMATOLOGICAL SOCIETY.—At the annual meeting, held May 25, 1886, the following officers were elected for the ensuing year:

President, Dr. R. W. Taylor.

Treasurer, Dr. E. B. Bronson.

Executive Committee, Drs. H. G. Piffard, E. L. Keyes, and P. A. Morrow.

According to the rules of the Society, Dr. Chas. W. Allen, the most recently elected member, becomes Secretary.

CHANCRE OF THE CONJUNCTIVAL CUL-DE-SAC.—Dr. Gillet de Grandmont reports the case of a Mme. B., æt. 26 years, who presented herself at his clinique with a conjunctivitis of the left eye, for which she had been treated during the past eight days. There was an intense injection of the conjunctival and episcleral tissues of the eye, the cornea was healthy, and the iris mobile. Upon depressing the lower lid, there was found in the conjunctival cul-de-sac, a little above the furrow, upon the globe, a large, red papule, elongated in the direction of the palpebral opening, and ulcerated at its summit, with grayish base. Its borders were elevated, and induration was evident; but as the mass could not be seized between the fingers, the characteristic sensation of an indurated chancre could not be obtained—a sensation which has been aptly compared to that of a button pressed beneath a fold of cloth. This papule seemed adherent to the sclerotic. An indurated gland in the parotid region confirmed the diagnosis of chancre.

Seven weeks later, there was an unmistakable papular eruption upon the face; neck, and arms, which rapidly yielded to subcutaneous injections of mercury.—*Journal de Médecine de Paris*, No. 12, 1886.

TREATMENT OF GONORRHOËAL HÆMATURIA.—Dr. Horovitz recommends as the best treatment for hæmaturia following gonorrhœa, which usually has its origin in erosions or rhagades in the neighborhood of the neck of the bladder, or in the contiguous portions of the urethra, that a *canule à demeure* be inserted for twenty-four hours. If cystitis be present as well, the canule may be utilized to wash out the bladder.—*Centralblatt für Chirurg.*, No. 12, 1886.

IODOL: A SUBSTITUTE FOR IODOFORM.—Iodol is a new substance which bids fair to take the place of iodoform. It is a dark powder obtained from "Dippel's animal oil." It has but little smell. It is soluble in three parts of absolute alcohol, but only in five thousand parts of water. It has been extensively tried in Rome in the treatment of chancres, buboes, etc., and very good results have been obtained. It has proved equally valuable in many cases of simple indolent ulcer.—*London Record*, Feb., 1886.

CHLORIDE OF CALCIUM IN SCROFULOUS AFFECTIONS.—Dr. Coghill's formula for scrofulous affections is to dissolve $\frac{3}{4}$ v. of the crystallized salt of chloride of calcium in $\frac{3}{4}$ xij. of syrup. Of this he gives \mathfrak{m} v. to \mathfrak{m} xl., according to age, in milk after meals.—*Exchange*.

A NEW DEODORIZER.—According to the *Birmingham Medical Review*, a saturated solution of sodium hyposulphite mixed with an equal quantity of water destroys the fetor of cancerous ulcers.

PERSONAL.—Dr. Chas. W. Allen, of this city, proposes to spend the summer at Richfield Springs, and study the effects of sulphur water in diseases of the skin.

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Original Communications.

FOUR CASES OF LATE SYPHILITIC LESIONS OF THE RECTUM.

BY

R. W. TAYLOR, M.D.,

Surgeon to Charity Hospital.

THE past few years have witnessed a marked change in the views of the medical world as to the relations of syphilis to stricture of the rectum. To-day it is quite generally conceded, that syphilis is frequently the cause of rectal stenosis, and although the etiological relation between that diathesis and the annular fibrous variety of stricture is not clearly and sharply made out, its occurrence in syphilitic subjects is by many admitted as being caused directly by syphilis, and not, as it has been claimed by some, a simple coincidence. Study and observation, extending over many years, in an extensive field, have convinced me that, as an etiological factor in affections of the rectum, syphilis plays a much greater part than it is now generally thought to do. Not only in its late stages is the rectum quite frequently affected by it, but also in its earlier periods it is prone, under certain circumstances, to involve that organ. In the present communication, I desire to place on record four cases of late syphilitic affection of the rectum. Of these cases, three were under my care, and the fourth was seen in the practice of a medical friend. I may here state that the present cases are not the only ones I have observed of late syphilitic rectal lesions, but that they are the only ones of which I have kept quite full records. Others occurring in hospital and dispensary practice were observed sometimes in haste, and

always with irregularity on the part of the patients, so that it was impossible to obtain a satisfactory history. In a later paper I propose to consider the relations of syphilis to stricture of the rectum in all its forms.

CASE I.—In June, 1878, S. C., a young man aged 28, of rather poor fibre, of light complexion, and very pale, came to me with an indurated chancre of the prepuce and glans. He had never been very strong, and his careless habits of life, and tendency to drink, had militated much against his health. His business called him to various parts of the country, and I am convinced that the rather severe course which syphilis ran in his case was due to his weakly constitution, to his irregular life, his addiction to alcoholics, and his failure to follow out the treatment ordered for him. In the early part of August of this year, he suffered from a generalized small miliary papular syphilide, which showed a tendency to become slightly pustular. Later on, he had iritis, severe cephalalgia, and persistent redness of pharynx, with mucous papules on tonsils and sides of tongue. During this period he was submitted to a mercurial and tonic treatment, which he underwent in, for him, a tolerably methodical manner. Absent from New York for nearly two years, during which he had taken no medicine worthy of mention, he returned in the fall of 1880, suffering from gummous infiltration into the soft palate and posterior wall of the pharynx. This condition was seemingly cured by Christmas, and the patient was, according to his story, free from any traces of syphilis, until the summer of the year 1882, when he had a relapse of the infiltration in the posterior pharyngeal wall. This was, as before, treated locally and internally with a mercurial and iodide of potassium mixture, with the result of a cure in about two months, at which time no redness of the pharynx was noted. There were, however, two atrophic spots, one above the other, extending up behind the soft palate, and seated on the posterior wall of the pharynx.

I did not see the patient again until the winter of 1883, and then learned that he had discontinued treatment for more than a year, had led a dissolute life, had had, while in Cincinnati, what was called inflammation of the brain, which he laconically remarked was a combination of whiskey and sunstroke, and perhaps a little syphilis. At this time I found him very thin, weakly, with little appetite, and suffering from a rectal affection. He said that during the summer, while in the far West, he had suffered from a severe but subacute diarrhœa, which lasted fully two months, and was attributed to the impurity of the water of the place at which he was stopping. Other persons, he informed me, had suffered in the same way. He said that after the cessation of the diarrhœa he suffered much from constipation, so that he was forced to resort to strong cathartics, and often to use, in addition, laxative enemata. During this period, including the months of September to December, he

began to feel an uneasy sensation in the rectum, and particularly at the anus, while at stool, and at various times during the day. He noticed that occasionally he had a gluey discharge, sometimes tinged with a small amount of blood. Just before his visit to me at this time he had a quite marked hemorrhage, in which he thought he lost a tablespoonful of blood. He was convinced that he had internal piles. Examination showed no trouble with the sphincteric portion of the rectum, but just about its junction with the ampullary portion, a distance of nearly two inches on the posterior and left wall of the rectum, was a distinctly thickened portion of mucous membrane, about one and a half inches long, by nearly two in width, having sharp, abrupt margins. It was raised fully one-third of an inch, and its surface was firmer, less elastic than the rest of the rectum, and presented the sensation of a warty, somewhat papillomatous growth to the touch. No pain was caused by careful digital exploration, nor by the speculum. To the eye, the patch or tumor was of a deep-red color, and numerous prominences, seemingly seated around the follicles, were scattered over the surface. At its inferior border, at about the middle of the swelling, was a fissure fully half an inch long, and seemingly about a quarter of an inch deep when the membrane was in its natural, unstretched condition. This fissure was the seat of slight ulceration. A small quantity of sanguinolent mucus ran down from the lesion. Knowing the history of the patient, I diagnosticated the case as one of gummatous infiltration of the rectal wall. The mixed treatment was prescribed internally, together with such agents and means as would improve nutrition. Locally he used every night, after irrigation of the rectum with a warm alkaline fluid, a suppository containing at first five grains of mercurial ointment, and later on, ten grains, in combination with a small amount of opium. I had much difficulty with the fissure, which underwent ulceration, but which was finally healed up by using during the day suppositories of iodoform. Care was taken that a soft movement of the bowels occurred every day.

After four months of such treatment, the swelling was nearly all dissipated, and a hardened and condensed condition of the mucous membrane was left. The patient then disappeared until late in the summer of 1885, not quite two years from the date of invasion of the rectal lesion. At that time I found a well-defined puckering of the membrane, resulting from a firm cicatrix, which was rather more than an inch long and not quite an inch in width. I have not seen this patient since, though I learned recently that he said he was quite well. I may add that I have seen an infiltration in the posterior and lateral walls of the vagina of a syphilitic woman 34 years old, which, though not as salient as the lesion in this case, was rather greater in surface.

CASE II.—Early in 1884 I was consulted by a lady 40 years of age,

from a neighboring town, who eight years before had been infected with syphilis by her husband. In the first two years of her disease she, as well as her husband, was ignorant of the fact that she was syphilitic, and it was only after much questioning on my part and efforts at recollection on hers, that she called to mind that she had had slight fall of hair, sore throat, and a mild rash. Her physician assured her husband, as I learned from him, that she had a mild, but rather chronic attack of diphtheria. During the first three years of her syphilis she aborted twice at seven and eight months respectively. In the winter of 1883, she noticed two swellings at the internal ends of each collar bone, which increased quite rapidly, and in February, 1884, each swelling opened and gave vent to a thin, gummy, purulent fluid. At about the same time she noticed that there was something wrong with her vagina, and that at defecation she experienced a sensation of hindrance of expulsion as she termed it, she did not seem to have the power she formerly had. She also noticed that when using a vaginal enema that the posterior wall was not as supple as formerly. She complained of no pain, but had noticed at times a small quantity of viscid mucus in her stools, particularly when constipated. She was a rather fat and flabby woman, with dark-brown hair, and a sallow complexion. She was not particularly weak, had a good appetite, and was cheerful in disposition. Upon examination, over each sternoclavicular articulation a well-marked gummatous ulcer of nearly the size of half a dollar, the base of which was formed by necrotic bony tissues. The anus was normal, but rather more than two inches above, on the anterior wall of the rectum, was a hard, firm patch or tumor of oval shape, of a diameter of fully two inches. It was elevated fully half an inch and had a convex, slightly papillated surface. There was slight tenderness in and around the tumor, but no abnormal heat nor discharge. On examination of the swelling bimanually, with the fingers in rectum and vagina, it was found to involve the mucous membrane of the rectum, and seemingly to encroach on the subcutaneous tissue between that and the vagina. Its shape was readily made out and found to be distinctly movable. The same course was pursued as in Case I., with good results. I examined this patient in February of this year, 1886, and could only find a slight contraction of the mucous membrane of the rectum, not enough, however, to produce the slightest obstructive symptom. The patient had then followed treatment for more than a year and was in excellent health. She informed me that she had not been as well in fully ten years as she was then.

CASE III.—In the summer of 1878, Mrs. O'C., Irish, 28 years old, married ten years, and the mother of two children, came under my care at the Bellevue Out-door Department. She was a very large, fleshy woman. She had had syphilitic manifestation for four years, having

been infected by her husband. She had nodes over the whole cranium and gummatous ulcers on the buttocks and legs. Though she was not as attentive as she should have been to treatment, the nodes had disappeared, and the ulcers were healed in November of that year. I saw little of the patient again until March, 1880, when she came complaining of what she called piles. She said that three months before she had given birth to a child at eight months, and that during her pregnancy and since she had suffered much from constipation, and latterly had felt much uneasiness in her rectum, from which there was a foul discharge. On examination, I found the anus red and inflamed, and on introduction of the finger two inches into the rectum, on its posterior and lateral wall was a deep ulcer with thickened and sharply cut edges, and of an area of fully two inches. A profuse, bloody, purulent discharge escaped. The woman at this time was much debilitated, and suffered from alternating diarrhoea and obstinate constipation. She was placed upon the mixed treatment, laxative cathartics were administered, and suppositories of iodoform and belladonna were inserted into the rectum after the use of warm alkaline enemata. I had much difficulty with this case at first, owing to the persistency of the ulceration. Later on, according to my directions, her husband, who was a practical mechanic, made an appropriate speculum of wire on the plan of that devised by Pinkham. By means of this I taught him to insufflate the ulcer with equal parts of subnitrate of bismuth and iodoform. The result was a cure in about two months. I hunted this patient up recently, and examined the rectum and only found a cicatricial ridge with no appreciable stenosis of the gut.

CASE IV.—The next case I saw in consultation with my friend, Dr. C. E. Lockwood, who kindly furnished me the following history:

K. W., female, aged 23, syphilitic five years, was first seen in May, 1885. She desired treatment for what she called an abscess. On examination, on the posterior wall of the vagina, about two and a half inches deep, was a ragged opening through which a probe could be passed into the rectum, and withdrawn through the anus; there was also a stricture of the rectum about two and a half inches up. The woman stated that she had discovered a lump in the posterior wall of the vagina about two months before, which was not accompanied with pain. She had for several months previously suffered from the local effects of the stricture of the rectum.

The case when seen by me presented a well-marked rectal stricture, just admitting the end of the index finger, and an opening the size of a quarter of a dollar, with ragged coppery-colored edges, which was much larger in the rectum than in the vagina, showing that the morbid process invaded the rectum first, and later on the vagina. The opening was just

below the lower edge of the stricture. The latter was of the typical annular fibrous variety. The woman was placed upon a tonic and anti-syphilitic treatment, with local medication, by which the ulcerating opening was closed in about four months. The treatment of the stricture was deferred to a later date.

40 WEST 21ST STREET.

THE USEFUL ADMINISTRATION OF ARSENIC IN DISEASES OF THE SKIN.

BY

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THE short article which appeared in the first number of the *New York Medical Monthly*, from the able pen of Dr. Fox, upon "The useless administration of arsenic in diseases of the skin," seems to me to call for a word of protest from some one who thinks better of this drug than Dr. Fox appears to do, and especially so since the editor of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, in the *Medical Record* of June 26, has made a general call for expressions of opinion upon this important subject.

The words of Dr. Fox and his argument, as he puts it, can hardly be controverted, but the implications of his article, and the generalizations which are sure to be drawn from it, seem to me to be damaging in their tendency, and likely to be effective of more harm than good; and therefore, since it is a very poor question which has not two sides, I wish to say a word on the other, and what seems to me to be the better side.

The general practitioner who has his routine prescription for all known symptoms, and who, upon seeing a malady of the skin, takes his pen and orders five-minim doses of Fowler's solution three times day, in the vague conviction that by so doing he has performed his whole duty to his patient, is undoubtedly condemned by this simple act, and all that need be said of him or to him is that he ought not to treat skin diseases at all.

The value of diet, of hygienic measures, of topical applications; the study of diathesis, and the just appreciation of the cause of a given skin disease—all of these are doubtless more valuable factors of treatment than the administration of any drug, and a physician is hardly worthy of the name if he relies upon medicines alone in the management of any malady—cutaneous or general. In so far, therefore, it appears to me that the generalizations of Dr. Fox are accurate; but beyond this they appear

faulty, because they seem by implication to attempt to weaken general confidence in a remedy which, carefully used, holds a very high, if not the first place in cutaneous general therapeutics, notably in the management of chronic disease.

The same rebuke (*i. e.*, routine administration) may, with equal justice, be cast at cod-liver oil and the hypophosphites as to their applicability to phthisical maladies, at colchicum, at quinine, at mercury, at iodide of potassium, or at any other drug. One man may use any of these remedies without effect against a malady over which they are well known to exercise a more or less controlling influence, and he may fail; while another practitioner, continuing the same remedy and intelligently supplementing it by other means, may conduct his patient safely to a cure.

I am not in a position to champion arsenic or any other remedy as a general "skin-success," but if there is any other drug more far-reaching in its influence for good upon the skin in a general way I have yet to learn it, and Dr. Fox has not suggested what it is.

My observation and experience in relation to the use of arsenic allow me to generalize only upon a few points.

Arsenic is distinctly a cutaneous stimulant; therefore, in the initial stage of a malady possessing an inflammatory element (notably eczema), it is not only not useful, but may be actually pernicious. Used after the acute stage has been controlled by appropriate means, it often speeds the parting guest and prevents it from lingering in a state of prolonged and desperate chronicity. A fitting analogy is the use of friction and massage in joint disease. This remedy is very efficient, but it has its time and place. When the joint is acutely inflamed, massage only adds fuel to the flame; but when the fire has been subdued, then the stiffness and loss of motion, perhaps otherwise inevitable, may be often overcome by the skilled application of massage. If the joint would get well without the massage, there is no call for its use, and no one but a routinist would employ it, yet that it has its use can hardly be denied, and so with arsenic.

Arsenic, in my opinion, is not useful unless the stomach tolerates it well and appropriates it in a kindly way. When digestion is interfered with by the use of arsenic, nausea or inappetence produced, it generally does no good, often harm. In such instances, preparing the stomach beforehand, changing the diet, disgorging the liver, giving attention to the patient's personal habits will allow the remedy to exert an influence, where unaided it would be without value or even harmful. The same remarks apply exactly to the administration of cod-liver oil, and often to the use of iron and other tonics.

The different preparations of arsenic may be called into play here in

selected cases. I have more than once taken a patient with chronic psoriasis, who had hopelessly given up the use of Fowler's solution because it troubled his eyes, ruined his digestion, and seemed to irritate his skin, and conducted him to a cure by combining arsenious acid with nux vomica and pepsin, with some changes in diet, or by substituting the arsenite of soda for the arsenite of potash. The Bourbonle water, a mild solution of the arsenite of soda, is a very gentle way of administering arsenic; too gentle as a rule, but yet I believe often effective of good, particularly in the case of weak digestion. Fowler's solution, especially if it has been long prepared, is very likely to disagree with digestion, and for this reason I seldom use it.

The more diffused, generalized, and chronic that a given cutaneous malady is, the greater do I consider the indication for the use of a suitable preparation of arsenic, if the stomach will take it kindly. The more localized an affection is, be it ever so chronic, the less indication is there for arsenic in a general way, in my opinion.

Generalized chronic eczema, generalized psoriasis, and pemphigus may, perhaps, be selected as the maladies in which arsenic may be expected to exert what may be termed a certain specific general effect in controlling the symptoms—exceptions to the contrary notwithstanding. Yet the combination of mild doses of arsenic with other remedies is not without value in some localized maladies, and in combating some forms of acne and some cutaneous manifestations of syphilis. Much also might be said, but more cautiously, in the case of neurotic maladies as affecting the skin, and where an element of nervous debility keeps down the patient's general vitality, and prevents other suitable remedies from being effective.

In short, I think that there is so much value in the intelligent use of arsenic that it seems a sin to allow its association with that time-honored humbug, promiscuous blood-letting, as an appropriate analogy to pass unchallenged.

1 PARK AVENUE, July 1, 1886.

TREATMENT OF CHRONIC URTICARIA.—In the treatment of this obstinate and distressing affection, Vidal recommends the bromo-hydrate of quinine, in doses of seven and one-half to fifteen grains, so as to secure the physiological effect of the drug. This should be continued fifteen consecutive days. The treatment should then be suspended and, if necessary, resumed again in a few days. Always a marked improvement, sometimes a complete cure is thus obtained. As a local application for the itching, he recommends lotions of a saturated solution of chloroform in water, the parts to be sprinkled with powdered starch before they become dry.—*Journ. de Méd. et de Chir.*, June, 1886.

THE QUESTION OF THE VALUE OF ARSENIC IN DISEASES OF THE SKIN.

BY

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THE editor of this JOURNAL has asked me to write a brief paper giving my personal experience as to the value of arsenic in skin diseases.

I shall willingly comply with his request in the hope that others may be induced to do likewise, and that, in this way, we may get at some definite conclusions regarding this vexed question of therapeutics.

For obvious reasons, which need not be entered upon here, it is a matter of the extremest difficulty to satisfactorily determine the precise indications for therapeutic agents, and the history of the employment of arsenic in diseases of the skin affords us a striking illustration of the truth of this observation.

As Morris¹ has stated, a study of the literature of this drug is unusually interesting, as exhibiting the "alternate excessive confidence in and excessive suspicion of it at different periods." As an example of this in our own day, we may note, on the one hand, the extreme credulity of Hunt, and the rather supercilious scepticism of Hebra.

I do not know of a better way of arriving at an expression of opinion in reference to the use and abuse of arsenic in dermatological practice than by offering a somewhat running commentary on the propositions recently presented by Dr. G. H. Fox to the New York Dermatological Society in a paper on the "Value of Arsenic in Skin Diseases,"² which I shall take up seriatim :

1. "*The very common practice of giving arsenic in nearly every case of skin disease is irrational and harmful.*"

This general statement will undoubtedly be accepted by all educated physicians, for a moment's reflection will show that cutaneous affections acknowledge the most varied etiology and present the most diverse pathological conditions, and no single remedy could by any possibility be of service in all, and would most likely prove injurious to some of them.

2. "*It is irrational because, in the majority of cases, the remedy produces very little, if any, benefit.*"

This second proposition follows as a corollary from the first ; for cer-

¹ "The History and therapeutic Value of Arsenic in Skin Diseases." Practitioner, 1880. I am much indebted to this valuable article for various facts relating to the history of arsenic.

² JOURNAL CUTAN. AND VEN. DIS., June, 1886, p. 179.

tainly, if the usefulness of the drug is restricted to a comparatively small number of maladies, it would be irrational to employ it in the majority of cases where little or no benefit could be reasonably expected from its administration.

3. "*It is harmful for the following reasons: a, In many cases it increases cutaneous congestion, intensifies pruritus, and thereby aggravates the eruption; b, It is very frequently relied upon to the exclusion of other and better plans of treatment.*"

To the first half of the proposition I would give a very hearty assent, since clinical experience is here supported by experimentation. Ringer and Murrell found that when frogs were poisoned by arsenic, the cuticle could be stripped off the whole body with great ease within a few hours after its administration. Certain experiments by Miss Nunn prove that "the general effects of arsenious acid upon the epidermis is to cause a degeneration and partial solution of the protoplasm of the cells, whereby (1) the whole epiderm becomes loosened from the subjacent derm, (2) the cells of the Malpighian layer become incoherent, so that the whole layer collapses and its well-known architectural features become obscured, and (3) the intermediate layer separates from the Malpighian layer below, and at times from the corneous layer above."¹

A consideration of the bearing of these important investigations on the remedial employment of the drug will show that its use is interdicted in acute cases, as it "increases metabolism in the cells of the epidermis" (Brunton), and consequently increases cutaneous congestion, intensifies pruritus, and aggravates the symptoms generally. As stated above, clinical experience amply confirms these researches, and it is with me an almost every-day occurrence to have my attention called to cases that have been made worse by the injudicious prescription of arsenic.

The second half of the third proposition (subhead *b*) is also undoubtedly true; thus, if arsenic is relied upon for the cure of a parasitic affection of the skin, and no appropriate local treatment is instituted, we are surely doing more harm than good. I take it, however, that Dr. Fox meant this statement in a somewhat different sense. I rather believe that here he refers to the large number of cases where arsenic is administered in a routine manner, as in some occult way "good for skin diseases," when such cases urgently require to be treated symptomatically and as regards their individual necessities. For example, a rosacea is often caused or kept up by some disorder of the stomach or uterus, and in such instances it would be the part of good practice to remove the exciting cause; but only too often this blind confidence in the efficacy of arsenic will lead to a neglect of the proper measures.

¹ Quoted by Morris, loc. cit.

As Niemeyer once said of blood-letting in pneumonia, that he sometimes bled in spite of the pneumonia, I think I may make this concession to arsenic, that I sometimes give it in spite of the apparent contra-indications to its use. In addition to its local effect upon the skin, arsenic also has a certain definite general action; therefore, in cases where I have had no desire to obtain its especial local influence, I have administered it for its modifying effect upon the economy, and especially the nervous system, and at times also when I wished to avail myself of its anti-periodic properties. But even here I should wish to postpone its employment until the acuteness of the cutaneous symptoms had somewhat abated.

4. "*The universal employment of arsenic in the treatment of skin diseases is no more a proof of its value than was the former practice of venesection for most diseases a valid argument in favor of that plan of treatment.*"

This proposition may be allowed to stand without comment. I may be permitted incidentally, however, one statement which relates to the reason of the widespread belief in the utility of arsenic for skin diseases. It has often happened in the history of medicine that when, in some way or other, a certain plan of treatment had been found advantageous in a given disease, all other cases of the same disease, or all diseases bearing a likeness to it, were immediately subjected to the same treatment, and as a proportion of the whole number answered the indications, the drug or plan of treatment soon became looked upon as nearly specific. This was far truer of former times than of the present, when the art of diagnosis is better understood, and is still in a measure true for dermatology, where skill in diagnosis is not a general accomplishment. Thus when Girdlestone, in 1806, first advocated the use of arsenic in psoriasis he hit upon the disease in which, in its chronic stages at least, it is of value and, therefore, when it was seen that it had a marked modifying influence on a "skin disease," and the differential diagnosis of cutaneous diseases not being well understood, it naturally came to pass that arsenic was soon looked upon as appropriate to all apparently similar troubles. A parallel case has arisen in our own days and, strangely enough, concerns the same disease. I refer to the use of chrysarobin, which, on account of its utility in psoriasis, is largely prescribed in general practice for nearly all skin diseases, and I must say to the great detriment of the patient.

5. "*The beneficial change which sometimes follows the use of arsenic is frequently due to adjuvant treatment and erroneously attributed to the administration of this drug.*"

6. "*In spite of the wide-spread belief in the value of arsenic, there has never been published a series of carefully recorded cases in which the sole administration of this drug has produced any notable therapeutic results.*"

These two propositions may be considered together. Undoubtedly it is true that for a large proportion of cases of skin disease the adjuvant treatment—and there is nearly always some such assistance—has done more good than the arsenic, and consequently most of the recorded cases in which arsenic was presumably the sole agent employed are worthless for purposes of study, since in the majority of such instances the diet and general hygienic surroundings have been looked after, and very frequently local applications have been employed. I shall delay consideration of those cases in which arsenic alone has apparently effected cures until we have examined Dr. Fox's next proposition.

7. "*There are some forms of chronic inflammatory skin disease, and possibly some affections of a malignant type, in which the internal use of arsenic will undoubtedly exert a beneficial influence.*"

To confine our attention first to the non-malignant group of diseases. As a result of clinical experience, fortified as it is by experimental proof, every dermatologist will readily admit that the internal use of arsenic will cause the disappearance of certain chronic inflammatory disorders of the skin, such as psoriasis, lichen planus, perhaps pemphigus, and probably a few others. After admitting so much, the question comes up: Are these results invariable; and if they are, are there no other plans of treatment that are quicker and better? Speaking from my own experience, I must say at once that arsenic often completely fails in the very diseases in which *a priori* we should expect the best results. In an excellent paper on the "Limitations of Internal Therapeutics in Skin Diseases,"¹ Dr. J. C. White uses the following language in regard to arsenic: "There is scarcely any affection in which it is not given by the profession with routine constancy. Its powers, however, are unfortunately very limited. For outside of this group (inflammations) it may be said to be powerless, while within it its action is positively injurious in the most inflammatory states of the skin, and of real service only in a very small proportion of the affections included in it. When I mention psoriasis, chronic eczema, lichen ruber, and pemphigus, I have named all of them in which we can confidently rely on it in any great measure. Even in these we know how often it utterly fails to accomplish what we expect of it, and how impossible it is to predict in any individual case, however favorable apparently, the measure or rapidity of its success. Upon the permanency of its influence in the recurrent forms of these diseases we cannot depend."

Mr. Jonathan Hutchinson vaunts arsenic as a specific in pemphigus but neither Hebra nor Tilbury Fox found it to be such. The latter expressly declares that "there is no specific for pemphigus. Arsenic is de-

¹ Archives of Dermatology, April, 1882.

clared to be one, but it often signally fails to cure the disease, and I have seen quinine in full doses do much more good."

Such has been my own observation, and in a case of pemphigus foliaceus under my care everything failed to benefit the patient. I may also say in this place that I have never seen the slightest good come from the use of arsenic in eczema or acne, except when the indications for its use were found elsewhere than in the skin, and then only in a limited number of cases.

Indeed, nearly all the chronic cases that come under my care have already taken the drug for long periods and in various doses. Acting upon a suggestion of Piffard's, I think, to the effect that a minute dose might accomplish what a large dose failed to secure, I have given arsenic in infinitesimal quantities in acute affections, but, I am sorry to relate, also without effect.

Admitting, however, that arsenic, even when given by itself, is capable of removing certain chronic inflammatory skin diseases—and this I have already acknowledged to be the case—I must still repeat my former question, viz.: Are there no other plans of treatment that are quicker and better? I must emphatically answer in the affirmative. While I know that arsenic will very often cause the disappearance of a psoriasis, I place infinitely more reliance on the local treatment, and if I were restricted to the one or the other, I should elect to use the latter. By the employment of local measures in psoriasis—*e. g.*, chrysarobin—the mode of action is about the same as comes from the internal administration of arsenic, with this advantage, that it is quicker and more direct; and I am confident, from much experience in the matter, that relapses are not more frequent under one régime than under the other.

I am aware that arsenic has been looked upon as a sovereign remedy in lichen planus, and especially good results are said to have been obtained by its hypodermic administration (Koebner); but here also it has been known to fail, and lately Unna has claimed much more rapid relief from purely local measures.

As regards the curative influence of arsenic on the malignant affections of the skin, it is a matter of medical history that the drug has been given in cancer, real or supposed, from the date of its first introduction into therapeutics; but I doubt very much if any modern surgeon would pin his faith to it. Not a great while ago, the profession was surprised and delighted with the report of Prof. Koebner's cure of a case of sarcoma entis by the subcutaneous injection of arsenic, and while there is no sort of dispute as to the correctness of the diagnosis, or as to the results obtained, the query arises: Will such a happy issue be invariable? Unfortunately, in my own practice, two cases of sarcoma of the skin treated by arsenic—one only by the hypodermic method—were examples of con-

spicuous failure. Nevertheless, I should try it again, if the opportunity offered.

8. "*In most cases of inflammatory skin disease, regulation of the diet, and such hygienic and medicinal treatment as tends to improve the general health of the patient will do infinitely more good than the routine administration of arsenic.*"

The essential statements in this last proposition have been sufficiently considered in the foregoing paragraphs; it is, therefore, only necessary to express a general assent to its conclusions.

Finally, I would say that I am far removed from therapeutic nihilism, and that I believe we have many agents which, when taken internally, are capable of influencing pathological conditions; but what I would most earnestly protest against is the crude idea of specific medication. There can be no such things as specifics, and a rational therapeutics must be based upon an intimate knowledge of both healthy and morbid processes. Therefore, to prescribe arsenic as in any wise a panacea for the majority of skin diseases, merely because of its efficacy in some of them, is highly unscientific and much to be deprecated.

MOLLUSCUM CONTAGIOSUM—AN ANALYSIS OF FIFTY CASES.

BY

CHARLES W. ALLEN, M.D.,

Surgeon to Charity Hospital.

"**M**OLLUSCUM contagiosum is so-called because it is *not* contagious."

I find this statement in my notes, taken at the clinic of an eminent professor of dermatology in Vienna a number of years ago.

Dr. Fox stated, at the meeting of the New York Dermatological Society, April, 1876, that he had never seen contagion, although children having the disease had slept with others under his observation. In his excellent paper read before the American Dermatological Association, 1877, he goes so far as to admit that "the remarks applied to warts that they appear sometimes to be contagious might equally well be applied to molluscum."

Kaposi says positively that there is no ground for considering the disease contagious.

Duhring does not commit himself, but prefers the name *molluscum epitheliale*.

Robinson says: "In spite of its name, the malady is in no way contagious."

I am not acquainted with the precise views of many of our American dermatologists on this question, but I know that there exists a great diversity of opinion.

Opportunities for studying the disease are not frequent, in this country at least, and none should be neglected which may help clear up the nature of an affection which, since its first description, has borne a name believed by half those using it to be a false one.

In February, 1883, there came to the New York Hospital a married woman, 25 years of age, to be treated for a group of molluscum tumors on the right side of the neck and a few scattered ones on the opposite side. They had first appeared, she said, seven months before, on the right side, at a spot where her child, who had also had the disease, rested his face when she carried him.

The child was examined, and found to have still remaining upon his face a solitary molluscum. The mother stated that her small brother, who lived in the family, was similarly affected. Here was almost the counterpart of one of the cases which led Bateman, in 1817, to give to this variety of molluscum the name *contagiosum*.

Dr. Bulkley inoculated my left arm in two places with some of the substance of the molluscum and the sebaceous-like material pressed from its central opening. For a week or ten days, I kept the spot carefully protected. After the irritation caused by the operation had all passed away, there gradually appeared at one of the points inoculated a little papule, which became elongated, flattened, and of a pink hue. It gave promise of developing into something, and then disappeared. I regarded it as an abortive attempt at reproduction.

Retzius claims to have inoculated the disease upon his own person.

Vidal reported to the Soc. de Biolog., *Prog. Méd.*, 1878, that in two cases inoculated molluscum had been produced; in one appearing in three months, and the other in six months after the inoculation.

Dr. Paterson, of Leith, claims to have practised inoculation successfully.

These reports do not appear to have carried much weight with them, for authors still say that inoculation has never succeeded.

Early in March of this year, I was called in consultation to one of the infant asylums of this city in which some skin disease had attacked almost a hundred of the children. I found them to be suffering from scabies, and some were in a pitiable condition. In making my examination, I discovered a case of *molluscum*, and being told by the matron that

many of the girls were similarly affected, ordered all such to be brought up. Some thirty cases were found at once.

From the matron, I learned the following history of the outbreak:

When Polly H. came into the institution one year ago, they noticed that she had these peculiar looking warts on her face, but gave no further attention to them. After she had been here for about three months, it was observed that not only had the growths enlarged and multiplied upon Polly's own face, but that many of the other girls were



similarly affected. In the matron's own words: "So you see one girl brought it in, and the others caught it from her." What more reasonable inference could be drawn?

I operated upon forty-two children, at several sittings, removing 133 tumors, of which I kept record, besides some smaller ones. They were distributed as follows: Eyelids and regions about the eye, 51; other

regions of the face and neck, 51; nose, 11; lips, 11; hand, 4; chest, back, arm, knee, leg, each 1.

The largest one was on the chest, and measured a centimetre in its longest diameter. The smallest were discovered on the vermilion border of the lips in two cases. They are shown in the engraving, which I would say is not the representation of a single case, but exhibits the actual lesions of several separate cases, accurately located and painted from nature.

The growths were removed for the most part with sharp spoon or dermal curette. A few were incised, pressed out between the fingers, scraped out with the finger nail, or pulled out with dressing forceps. Some were also cut off even with the skin's surface, and the deeper part pressed out. In most cases where the remaining cavity was not scraped out, it was touched with the solid stick of nitrate of silver. The patients all being girls, I was anxious not to leave scars or staining, and hence used the caustic stick sparingly, relying upon the sharp spoon. When scraped out whole, the growths have a peculiar, gland-like structure, and resemble a diminutive brain.

Among the children sent to me as being affected with molluscum, I found some to have only verruca vulgaris, or common warts, the nurses and the children themselves considering them all of the same variety. This co-existence of similar growths impressed me at the time, and I examined all of the cases in reference to warts. Sixteen were found, eight being in patients entirely free from molluscum and eight in children having the disease. On the arms of several of the patients I found a flat variety of wart with a pink border, which resembled the mollusc tumors in a measure, but had no central opening, were of firm consistence, difficult to remove, and did not present the gland-like structure. They were also situated on parts not commonly occupied by warts, and in one case formed a small group. I have since read the paper of my friend, Dr. Fox (American Dermatological Association, 1877), in which he speaks of this co-existence of verruca and molluscum, and suggests a possible common cause or some close connection. We must, however, remember that warts are very common in children, and molluscum but rarely encountered.

This is a larger number of cases occurring together than I find anywhere recorded as having been observed, and I took advantage of the favorable opportunity thus afforded to make some observations on the nature of the disease.

Regarding the result of the previous inoculation practised upon myself as an abortive effort at reproduction, and considering the clinical history of the disease to warrant the belief that it is sometimes propagated by contact, I inoculated two of the children with the soft substance from

a molluscum tumor, and some of the firmer part as well. I chose those who had had the disease, as being the most likely subjects, and made the inoculation on the face, protecting one point for some days with a watch glass, and gave instructions for certain precautions to be observed. Three months later no signs of reproduction had appeared.

Upon visiting the institution on June 19, over three months from the date of operation, I found that twenty-eight of the children treated had remained entirely free from the disease, four had left the institution well, twelve children presented new crops of mollusca, in four instances scattered about the neighborhood of original lesions, but none at their actual site. In several instances the growths had appeared on entirely new regions.

They were all situated upon the face and neck with the exception of one solitary lesion upon the shoulder. No scars were discoverable as the result of operation.

Besides these twelve cases in which the tumors had reappeared, there were found five children, not previously affected, in whom they had developed.

The inoculation of the children having so far resulted in nothing, I now inoculated myself again in two places upon the soft skin of the flexor surface of the forearm, and have since kept the part covered with a watch glass, and somewhat moist. Some pain was experienced for a few days in the arm and axilla following the procedure, and the epitrochlear gland was painfully enlarged, and is still quite tender. I will make known the result at some future time, together with anything worth reporting, from my efforts to discover the microbe of molluscum, whose existence I think highly probable.

It has been suggested that irritation of the skin is a potent factor in the production of the disease, and it will, without doubt, occur to those who hold this view that in this series of cases the most favorable conditions for its development existed. Here we had an epidemic of scabies with all the attendant surface irritation.

I cannot think, however, that this irritation alone is sufficient to cause the disease. Over a hundred of the children suffered from scabies, while less than fifty had molluscum. Many of those who had molluscum did *not* have scabies, and in other respects their skins were healthy and free from irritation. The faces thickly studded with mollusca were, as a rule, remarkably free from scabies, while scarcely a tumor was found upon the scratched and irritated body.

Other writers have claimed that maceration of the skin and frequent bathing greatly favors its production. All of these children were regularly bathed, and those with scabies quite frequently, still it is safe to say that none of them had as much attention paid to the cleanliness of

the body as the children of the better class, in whom the disease is rarely seen. On the contrary, molluscum is commonly found in poor and uncleanly families. It appears to me, however, that maceration or moistening of the surface from perspiration may favor the propagation of the disease by contact, as when the face of an infected child presses against the mother's face or breast, thus producing a more favorable nidus for the contagious principle.

I do not wish at present to touch upon the pathology of the disease, but would regard the existence of mollusca in the cases mentioned upon the vermilion border of the lips as a strong clinical point against the theory and belief of some that molluscum contagiosum has its origin in the sebaceous glands. I believe that no sebaceous glands are to be found in this portion of the lip. Nor yet would it appear that the disease can, in all cases, originate in the hair follicles.

Virchow, Bizzozero, Piffard, Robinson, Perls, Thin, and others oppose the view of Hebra, Kaposi, and their followers, that the disease is of sebaceous origin.

In fifteen tumors examined by Thin, hair or sebaceous gland structure was found in but one case. One of the tumors is shown in the drawing on the upper eyelid, pierced in its centre with an eyelash. I removed the tumor and hair together, but have not yet made a section for examination.

In conclusion, my present reasons for believing this molluscum contagious, and that its name is a proper one, and should be retained, are:

1. The cases reported by Bateman, Mackenzie, F. Fox, Liveing, and others, and the first one mentioned in this paper, where the child first has the disease, and the mother afterward, upon the face, neck, or breast, are difficult of explanation by any other theory.

2. The spread of the disease in families, schools, and institutions. Liveing (*Lancet*, Oct. 5, 1878) reported nine cases occurring coincidentally in a school.

3. The facts that the parts exposed to contact are those almost solely affected: The face in children, the breasts in mothers, and the genital region in adults, and especially in prostitutes and the men who visit them.

4. The reported successful inoculations.

5. That negative evidence has no weight. It is not always possible to inoculate other diseases which are well known to be contagious.

Finally, the disease should never be mistaken for any other, although Bazin considered it sufficiently like variola to name it *acne varioliformis*. It bears a slight resemblance to varicella, and when occurring upon the genitals has suggested syphilis to those unfamiliar with its appearance. From molluscum fibrosum the diagnosis is easily made.

Correspondence.

TREATMENT OF RHUS-POISONING.

SAN FRANCISCO, Cal., June 19th, 1886.

To the Editor of the Journal of Cutaneous and Venereal Diseases.

SIR:—Living in a country where rhus-poisoning is quite as prevalent, if not more so, than anywhere else, it is but natural that we should feel interested in this subject, and that everything bearing upon it should attract our attention, more especially so when we see an article referring to it, so ably written as the one which appeared in the June number of your journal. Poison oak is very abundant in the country around San Francisco, and is also found for hundreds of miles in every direction from this city. It is the very bane of our camping and pic-nic parties, in fact, of all whom business or pleasure calls into the country. As is well known, some are poisoned by it from simply passing in the neighborhood where the shrub grows, while others again enjoy such an immunity from its effects, that they can handle, or even chew its leaves and branches, without ill effects. As there is no specific for the cure of this affection, and as all remedies fail us now and then, our physicians out here are continually trying all therapeutic means to obtain one which will be invariably successful. All the remedies that you have mentioned in your paper, and many more, have been tried. I wish to call attention to one means of treating this affection which I have not seen mentioned in print, which is more efficacious than any other with which I am acquainted, to wit: Russian baths. I am convinced, not only from an extensive trial in my own practice, but also from the reports of my colleagues who have used them in this trouble, that they excel for efficacy and rapidity of good effect any other mode of treatment. It may be stated, as a general proposition, that they are the treatment *par excellence* for poison oak. My friend Dr. Loryea, of the New Hammam, of this city, formerly of the Windsor Hotel baths, of New York, who has also employed them in hundreds of these cases, informs me that he has had excellent results, and that they rarely fail to afford immediate relief. A number of baths may be required. Sometimes it may be necessary to use in addition a mild protective ointment containing zinc, bismuth, or lead—the baths, however, being the basis of the treatment. The beneficial effects of any lotion will be materially heightened if it be applied warm, provided that it be one adapted to the case.

Trusting that I have not trespassed too much upon the time and patience of your readers, I remain,

Yours fraternally,

ALFRED E. REGENSBURGER, M.D.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

Chronic Œdema of the Lids and Eczema of the Nose.

IN one of the last meetings of the clinic of the St. Louis Hospital, in Paris, Dr. Besnier spoke of the nature and pathogeny of certain chronic œdemas of the eyelids, especially of the lower lids, which come to resemble puffy cushions. The face also presents a certain amount of swelling. When the patient is first seen, one naturally thinks of a renal affection, which the examination of the

urine shows to be unfounded. Formerly these lesions were attributed to erysipelas, or rather to repeated attacks of lymphangitis, and, indeed, we sometimes observe inflammatory phenomena. The labors of Dr. Vérité have shown that the greater part of these chronic oedemas of the lids have a close connection with chronic eczema of the nares. If this eczema is propagated in a downward direction, it may cause fissures, and more especially a thickening of the upper lid, which is so often met with in strumous subjects. When, on the contrary, it spreads upward, it produces the oedematous infiltrations of the eyelids of which we have spoken. It must not be understood that eczema of the nares is the only lesion which can produce this condition, for it is also observed in lupus and syphilitic lesions of slow development which affect these parts.

These varieties of eczema are of the most rebellious character. Dr. Besnier advises a general treatment, with cod-liver oil in winter, and in other seasons arsenic, together with topical applications, if necessary.

Frequent spraying of the nares with tepid Saint Christan water is beneficial, or, if this mineral water cannot be obtained, with tepid water containing from fifty centigrams to a gram of sulphate of copper in each quart.

In the intervals of the spraying, small pledgets of cotton should be introduced within the nares, spread with an ointment containing ten grams of diachylon ointment to each twenty grams of vaseline or oil, or with an ointment made with a gram of yellow precipitate to each twenty grams of vaseline (Vidal).

Some cases of oedema of the lids are so marked that we should produce punctures at the most tumefied points, with the finest Paquet's thermo-cautery. By this treatment the swelling is reduced with much greater rapidity.

Eczema of the Anus.

We all know to what extent eczema located in the region of the anus can be tenacious and obstinate, and we are often consulted, by arthritics in particular, who have been affected for years, and in whom the skin of the perineum, of the margin of the anus, and of the anal commissure has finally thickened under the influence of repeated inflammations. We are now considering a condition to which the old French writers gave, with so much reason, the name *eczema lichenoïde* of the anus.

To cause this lesion to disappear, and to prevent relapse, we must take a number of precautions. Besnier, in his clinics, recommends his patients to take an enema of tepid water after each passage, retaining it but a moment; and to wash the parts frequently with tepid water, in order to remove all irritating matters. At night a slightly warm cataplasm made with potato-starch powder or flax-seed meal should be applied. If the pruritus is intense, pledgets of lint smeared with cocaine ointment may be introduced into the anus. The patient should abstain from spicy dishes, and especially avoid pepper. I will add to the recommendations formulated by Besnier the following observations:

It is absolutely necessary that direct contact should be prevented between the affected parts. The cataplasm must, therefore, be introduced at night, deep into the groove between the buttocks. During the day the affected parts should be covered with an ointment of oxide of zinc of the strength of thirty grains to the ounce of vaseline, and over this should be sprinkled oxide of zinc and subnitrate of bismuth in equal parts, finely powdered; some old fine linen, also powdered over with the same, is to be placed deeply in the groove between the buttocks. Bathing trunks furnish an excellent means of retaining the dressing in place. In

rebellious varieties of the disease, these soothing methods of treatment will not produce a cure in every instance. It becomes at times necessary to treat these lichenoid eczemas of the anus by applications of oil of cade in twenty, twenty-five, and fifty per cent ointment, or with a three to six per cent nitrate of silver wash. If these means cause too violent inflammation, they must be replaced, for a time, by poultices and soothing ointments, to be resumed again, and in this way, in almost every case, a cure will finally be effected.

Lichen and its Treatment.

We find the following mode of treating lichen formulated by Dr. E. Vidal in his recent article (*Annales de Dermat. et de Syphiligr.*, 1886), à propos of certain varieties of circumscribed lichen, and in particular that form which he designates by the name of chronic lichen of the genital and anal regions. This, in reality, is nothing more than the inveterate form of what I have just designated under the name of lichenoid eczema of the anus. It is well known that the researches of Hardy and of the Vienna school destroyed the old group lichen. Hardy places it among the eczemas, and Hebra less exclusively described certain forms of it under the name prurigo. Lichen ruber, which is a special affection, cannot be cut out of the nosological tables, and as to lichen scrofulosorum, for which the Vienna school preserve the name lichen, it is undoubtedly only a variety of acne. Dr. Vidal protests against this conception of the lichenoid lesions of the skin. He clings to the old group "lichen" of the French writers, but no longer classing under it lichen pilaris, which is only an exaggerated degree of xeroderma, nor lichen scrofulosorum.

He admits two principal varieties of lichen.

1st. Lichen simplex which may be: A *acute*, or B *chronic*. A. Acute lichen simplex is, a, *partial*, or b, *general*. This category includes the lichen simplex of authors; lichen lividus and the most of the strophulus group, excepting the strophulus albidus, candidus et volaticus, which are only in reality urticarias, and excepting strophulus having large papulo-vesicles which are probably polymorphous erythemas occurring in infants. B. Chronic lichen simplex can also be *partial* or *general*, and in this group also are included lichenoid eczemas or the chronic lichens formerly described, according to their form, under the name lichen circumscriptus, perpendicularis, and gyratus, which develop on the neck, buttocks, genital regions, etc.

2d. The second great variety of lichen described by Dr. Vidal is polymorphous lichen. He divides it into two sub-varieties. A. *Lichen polymorphus mitis*, comprising lichenoid eruptions of quite rebellious character, often *professional*, such as baker's itch, grocer's itch, and that seen in workers in factories who handle irritating substances, etc. B. *Lichen polymorphus ferox* which corresponds to the lichen agrius of the old writers, and to the true prurigo of Hebra and the Vienna school. In this connection the author protests against the name "Hebra's prurigo," which most French dermatologists have given to this affection. He well remembers that before the publication of the Vienna school, this disease had been perfectly described by Cazenave, Bazin, and Hardy. He also thinks that we should preserve its name lichen. He makes of it an ordinary lichen, modified in its appearance and clinical aspects by the terrain, at the same time scrofulous and nervous, on which it develops. I will not enlarge further upon the views of Dr. Vidal nor upon the discussion which they elicited, but the preceding explanations were necessary in order to characterize the forms of

affection in which the therapeutic measures brought forward by this author should be applied. In the internal treatment of the different varieties of lichen, he especially recommends a rigorous regime, abstinence from coffee, tea, wine, and liquors; the avoidance of loss of sleep, fatigue, violent emotions. The exclusion from the dietary of salty food, pork, game, salt cheese, shell-fish, and sea food generally.

Whenever the itching becomes violent and causes sleeplessness, opium may be administered by the mouth or by hypodermic injection, or bromide of camphor, bromide of potassium, or chloral given, provided that in the latter case alcohol is not used with it, as a chloral erythema might thus be produced. The author has succeeded very well in such cases with valerian castoreum, and in some rebellious cases with musk in daily doses of a drachm of the tincture.

Dr. Vidal believes that arsenic may be efficacious in chronic lichen simplex, and he prefers to administer it in the form of arseniate of soda.

R Sod. Arseniat 0.10
Aquaë destillat..... 100.

M. Sig. Teaspoonful in the morning before breakfast; after seven or eight days two teaspoonfuls.

Arsenic does not succeed so well in polymorphous lichen (prurigo of Hebra), especially when given in large doses. I will not dwell upon the author's treatment of acute lichen simplex; it is that of the older French dermatologists, excepting perhaps his vinegar and starch baths (a quart of vinegar to the bath), and lotions of decoction of slippery elm root, to which are added a fifth or a quarter part of vinegar or alcohol.

The skin is to be rapidly moistened with this wash, then, without drying, powdered over with starch powder, or with a mixture of starch powder 4 parts, and of oxide of zinc 1 part.

In chronic lichen simplex, the author employs extensively an ointment composed of tartaric acid, one gram, to twenty grams of glycerole of starch, made with Price's neutral glycerin. In obstinate cases he resorts to the methods which I have mentioned in speaking of lichenoid eczema of the anus.

In the forms which correspond to the prurigo of the older writers, which are characterized by disseminated and very large papules and by intolerable itching (prurigo simplex, senilis, and ferox), the author prescribes bathing with the following solution:

R Hydrat. Chloral..... 5 to 10 grams.
Aq. Laur.-Ceras..... 50 grams.
Aquaë..... 200 grams.

In some cases saturated chloroform water, or a solution of bromide of potassium, or finally hot water, to which camphorated alcohol has been added, greatly relieves the patients. In the most obstinate cases we must resort to the treatment employed in polymorphous lichen (Hebra's prurigo).

Dr. Vidal enters into minute details regarding the treatment of the latter affection, and calls to mind the practice of Hebra which consisted, as is well known, in frictions with cod-liver oil, sulphur soap or tar, and sulphur combined, etc. Kaposi's treatment, with naphthol ointment in from three to five per cent strength, also that of the former physicians of the St. Louis Hospital, who submitted their patients to applications of oil of cade, phenic and salicylic acid,

diachylon ointment, Wilkinson's ointment, and occasionally sulphur baths, and the routine treatment for scabies. After many trials we have come to employ cod-liver oil extensively at the St. Louis Hospital. Its introduction into the therapeutics of this affection, by the way, is not due to Hebra, but to French dermatologists, since we find this method mentioned in the works of Gibert.

Dr. Vidal has rendered a real service to medicine in having made a plaster of cod-liver oil, which greatly facilitates the application of this substance. The formula is: simple plaster with litharge and cod-liver oil, 600 grams; yellow wax, 250 grams; cod-liver oil, 350 grams; dextrin, 20 grams; water enough to dissolve the dextrin. This plaster has given him excellent results, not only in polymorphous lichen (prurigo of Hebra), but also in all other obstinate lichenoid affections of the skin. He has used with equal service the following: simple plaster, 600 grams; yellow wax, 250 grams; white oil, 400 grams; dextrin, 20 grams; water enough to dissolve the dextrin.

This ointment must be kept free from moisture. I am convinced, for my part, that cod-liver oil is the drug for Hebra's prurigo (lichen polymorphus of Vidal).

I have succeeded in curing a little girl of five years, whose parents had not seen her face since the age of sixteen months, as since this time it had been a mass of crusts covering a raw surface.

I gave the child from three to six dessertspoonfuls of the oil per day, and covered her from the head to the feet with the same. At points where too much itching is caused I followed the advice of Dr. Besnier, in applying naphtholated cod-liver oil. Naphthol β , 10 grams; cod-liver oil, 100 grams. This mixture calmed the pruritus in a marked degree.

At night the child was tied on the bed, with feet and hands attached to the railings, so that during sleep she could not wound herself by scratching, which she always did when left free. I believe we must not content ourselves with making external applications of cod-liver oil, but must give it internally as well.

Dr. Vidal thinks these patients are benefited by weak sulphur water, and advises their being sent to Uriage, St. Gervais, and to the sulphur springs of Luchon. In the most inveterate cases prolonged baths of Louèche (Valais, Switzerland) may be found useful.

Treatment of Psoriasis.

In one of his recent clinics, Dr. Besnier dwelt upon the fact that, no matter what therapeutic measure may have been employed in certain cases of psoriasis, there sometimes remain for a long time, at points where plaques have existed, brown pigmentations, which the older writers attributed exclusively to arsenical treatment. While admitting this as perfectly true, I think I can add that these macules are much less frequent when oil of cade is employed than when either chrysophanic or pyrogallie acid is used. Dr. Besnier likewise remarks that we cannot formulate for psoriasis a unique medication which will apply to all cases. The means must vary with the period of disease, its distribution, and the degree of irritation of the skin. This is the means he now recommends when we have to treat a discrete eruption characterized by a few scattered patches.

Cleanse the psoriatic patches with the greatest care by means of repeated baths and frictions with brush and soap; then rub the diseased points with a brush impregnated with a ten-per-cent pyrogallie acid ointment, then leave on the spot a layer of ointment as thick as a case-knife blade, and cover it over with a flannel bandage. In five days, the whole is to be removed, a bath given, and

the treatment repeated. When this dressing is made with care, only four or five applications are required to bring about complete disappearance of the disease.

But when the surfaces treated are quite extensive, the urine must be carefully watched, as the absorption of pyrogallie acid might cause serious trouble. I have experimented in my service at the Hôtel Dieu, at the time I had the honor to replace Dr. Moutard Martin, also in the service of Dr. Vidal, at the St. Louis, with the various means of treating psoriasis. I believe that for psoriasis characterized by a few isolated patches, the application of Vigo's plaster with mercury constitutes one of the best modes of treatment. The plaster is left applied to the part for two days, then removed, the parts bathed with black soap, and a new piece of mercurial plaster applied, and so on till the plaque has entirely disappeared, which takes place in from six to twenty days. A red plaster, formulated by Dr. Vidal, and composed of minium and cinnabar, 5 parts to 25 of diachylon, may also be used. Salicylic acid plasters, in ten or twenty per cent strength, which I have used, are much less efficacious. On the contrary, following Dr. G. Elliot's practice, I have experimented with collodion dressings composed of salicylic acid, 1 part; pyrogallie acid, 5 parts; collodion, 50 parts. I first cleanse the psoriatic patches, and apply the collodion, renewing it every two or three days, or whenever I see that it is becoming detached. I then give a bath, and apply another layer. This treatment is quite active, and among the most efficacious. In one instance, a single application sufficed to make the patch disappear. It is true that in this case the collodion remained adherent during several days, and caused marked inflammatory reaction, attended with severe pain. This method would be excellent were it not painful, and did it not irritate the skin of certain patients, especially those of strumous habit, in whom it determines inflammatory eruptions, phlyctenulæ, ulcerations, and lymphangitis, and also expose the patient to accidents of poisoning from the pyrogallie acid, such as I have seen from too extensive use of this collodion. I have also tried the following collodion: Pyrogallie acid, 5 grams; collodion, 50 grams, on the same patients who were using the above formula, treating the right side with the one and the left side with the other. I have found in this way that the latter collodion is less painful, less irritating, but a little less active than the former. Salicylic acid consequently increased the power of the pyrogallie acid. On the other hand, collodions with ten to twenty per cent salicylic acid, which I have used in the same way, are very painful and irritating, and much less efficacious than those of pyrogallie acid.

DR. L. BROcq.

PARIS.

Selections.

THERAPEUTICS OF SYPHILIS.

At the last "Kongress für innere Medicin," held at Wiesbaden, considerable attention was given to the above subject, in which Professor Kaposi, of Vienna, led in the discussion. He called attention to the fact that to-day, as four hundred years ago, mercury constitutes the standard treatment, and only a single addition has since been made to the therapeutics of syphilis. He did not hesitate to affirm, however, that not only was syphilis a curable disease, but that of

the different infectious, constitutional diseases, it was the one which, with proper treatment, was most easy of being thoroughly eradicated from the system. He propounded three questions, and proceeded to discuss each in its turn. His first question was:

Is there any positive method whereby the primary effects of syphilis may be treated and an immediate eradication of the disease thus produced?

If the initial step of the disease be viewed in its proper light, to wit: that the specific virus remains for a certain (although indefinite) time in the primary lesion, and is drawn up from here into the lymphatics and blood-vessels, three possible means present themselves of effecting the desired result. They are: I. The destruction of the virus at the point of infection in and with the primary lesion, by means of cauterization or excision. The objections to this are that we are absolutely without any data as to the time that the syphilitic virus may remain in a lesion before it is absorbed, and that even favorable results are not of statistical value because every sclerosis is not followed by the disease. Neither the presence nor the absence of glandular enlargements gives us definite data for knowing whether a primary lesion be syphilitic or not. If the relation of Lustgarten's bacilli to syphilis were fully demonstrated, their presence would doubtless constitute an effective criterion for the diagnosis of primary lesions. Excision is practicable when coupled with certain advantageous, topographical circumstances, as, for instance, if, on the margin of the prepuce, but almost wholly impracticable if on the glans or in the sulcus. Emplastr. hydrarg. is effective in the local treatment of the primary lesion. II. The disturbance or destruction of those vessels which constitute the immediate path of absorption of the virus. Prof. Kaposi thinks that whoever first made this suggestion should have accompanied it with more specific instructions. Which lymphatic vessel shall be severed? The whole penis lies imbedded in a web of lymphatics, and, without more exact knowledge, how can the prevention to be incurred by the very sweeping operation necessary under the circumstances be kept down to its traditional proportional ounce? III. Preventive measures. Although it is theoretically wrong to proceed with the eradication of a disease by first letting it fully develop, still he has observed that an early treatment does not prevent the subsequent appearance of tertiary symptoms, which, under such circumstances, often appear, and in severe forms. He urgently advises not to be too hasty with the mercurial treatment.

The second question was:

What are the respective advantages of the different remedies used in the treatment of syphilis?

Hospital statistics are of no avail, because the patients usually disappear as soon as the lesions have been removed; and since private statistics are not to be had, we are referred to individual cases, from which it is impossible to form comparative judgment. Mercury is applied endermically, hypodermically, and through the organs of digestion. Of endermic means, the inunction method with ung. hydrarg. is the most important. The plain ointment is the most reliable and efficacious means of treating early syphilis. Lanolin ointments and mercurial soaps (the latter of which is quite effective) are not as desirable as the first method. Intestinal affections and pyalism very infrequently accompany the application of the blue ointment, and by means of it is obtained a happy medium between absorption and elimination. Hg. plasters and Unna's Hg. plasters are generally of little use, but may be applied with advantage in the local treat-

ment of irritative and later syphilitic sores. Mercurial baths are very efficacious in the treatment of newly-born infants and adults suffering from ulcerous eruptions.

The hypodermic method is direct, exact, and convenient, and beside the original sublimate solution of Lewin a number of other preparations have been experimented with. The following three groups of Hg. remedies have been arranged by Bockhart with reference to their permanency :

1. Most permanent :
 - a. Inunction method (ung. hydrarg.).
 - b. Calomel injections
 - c. Lewin's sublimate solution
 } subcutaneous.
2. Moderately permanent :
 - a. Sublimate-chloride of sodium
 - b. Hg. albuminate and peptonate
 - c. Blood-serum mercury
 } subcutaneous.
3. Less permanent :
 - a. Hg. bicyanide
 - b. Hg. glycoll
 - c. Hg. formamide
 } subcutaneous.

The formamide is the least painful.

Internally, the customary Hg. preparations (sublimate, calomel, and hydroxyd. tann.) act usually more slowly than the others ; still, they are quite effective, and especially the last causes but slight discomfort to the stomach. In France, proto- and deuto-iodide of mercury find great favor as internal remedies.

Mercury is best adapted for all forms of affections of the skin, both in the early and late periods, and in acute conditions of the bones, the parenchymatous organs, and of the cerebro-spinal system, whereas the later nervous affections of the joints and cephalalgia syphilitica yield decidedly more quickly to iodine treatment. The more promptly and actively treatment is begun in the first *acute* stage of the disease the less is the probability of a relapse. Therefore, inunctions, or, if these are not possible, injections should be energetically begun at the proper time, and the most permanent remedies should be selected. All slow-working remedies cause only a prolongation if applied in the acute stage. Only in case of later affections, such as localized papulous formations, may they be applied, but in affections of a dangerous nature, such as iritis, ulcerative nasal or throat affections, or those of the brain or spinal column it is essential to use the most energetic means, and especially the inunction method with ung. hydrarg.

Iodine is especially good in cases of bone and joint affections and also for nocturnal pains in the bones and in the head. It can also be prescribed for syphilitic symptoms during the later periods, but should *never* be used alone in the beginning of the disease, owing to the protracted course of eruptions which follow it. That iodine can be used as a corrective against the misuse of mercury is a total misconception and utterly without foundation.

Zittmann's decoction of herbs is a very potent measure for later stages, and especially for ulcerative formations of the skin and throat. Prof. Kaposi often combines the use of this decoction with inunction, and observes that the presence of Hg. does not affect its activity.

Sulphur-baths, sea-baths, and hydropathic treatment have not the slightest specific effect upon the disease.

How long should treatment be continued?

Concerning the third question, as to the length of time and the repetition of treatment, Prof. Kaposi advised a long and careful course for from three to six months, and to repeat the treatment only when relapses occur, and not in order to prevent them. He did not object, however, to a light course of treatment for safety's sake.

Prof. Neisser, of Breslau, did not agree with Prof. Kaposi in his views with reference to an advisable delay in the treatment. He believed in cauterization with concentrated carbolic acid, or, if possible, excision. He believed it advisable to use every opportunity for the prevention of the outbreak of syphilis, and destruction of its virus. He agreed generally with Fournier in his views, and in the treatment preferred, as he said, to recognize the individual, and fashion his treatment thereafter than to recommend any single system for all cases.

Prof. von Ziemssen, of Munich, recommended especially hypodermic injections of bichloride of mercury, and after a lengthy discussion Prof. Kaposi closed by expressing the hope that physicians generally might add statistics from their private practice, so that more extensive data may be available.—*Deutsche Med. Wochenschrift*.

RESORCIN.

THE *Centralblatt für die ges. Therapie*, March, 1886, contains the following observations concerning resorcin by M. Ihle, of Leipsic, reported by Jarisch. The specific antiseptic properties of resorcin can be best noticed in herpes tonsurans. After two or three applications of a strong resorcin ointment the inflammation is allayed, and if the plates of epidermis tanned by the resorcin are removed, it will be found that only in those hairy regions where the spores have made their way to the bottom of the hair follicles is it necessary to continue treatment.

A very great advantage in the treatment of parasitic sycosis with resorcin is that the beard need not be epilated, the hairs loosening of themselves under the treatment. The pastes used should be applied two or three times a week, thickly with a brush, and rubbed well into the parts, which are then to be covered with cotton. It is at all times well for the physician to apply the preparation himself, and increase the strength with the progress of the cure. For instance, if the first application is a ten-per-cent paste and causes no great irritation, the next may be of twenty-five per cent, and the strength may be thus gradually increased to fifty or eighty per cent, then when the pus formation and irritation begin to decrease, applications must be continued in decreasing strength, following a similar scale.

As spores may still exist in a case of apparent cure, it is advised to give the patient a three-per-cent salve to apply at first daily, and later on once or twice a week. Now, for the first, should shaving be permitted, because in the energetic treatment with resorcin, shaving should be absolutely forbidden on account of the irritation which it causes.

The following ointments are recommended.

R Resorcin purissim.....	10
Vaselini albi.....	50
Amyl. Oryzæ,	
Zinci Oxidi.....	āā 25
M. ft. past.	

With an increase in the amount of resorcin, it is necessary to decrease pro-

portionately the zinc and starch. Therefore, for stronger ointments, the following is used.

℞ Resorcin puriss.....	50
Vaselin. albi.....	60
Zinci Oxid.,	
Amyl. Oryzae.....	āā 20
M. ft. past.	

The author speaks of resorcin in the treatment of pityriasis versicolor and eczema marginatum as being attended with absolutely sure results. He also recommends it in the treatment of alopecia areata and seborrhœa cum defluvio capillorum.

For these he uses:

℞ Resorcin puriss.....	5.10
Ol. Ricini.....	45.
Alcohol.....	150.
Bals. Peruv.....	0.5
M. S. Apply daily to head with a flannel rag.	

The itching of the seborrhœa is said to cease entirely under this treatment.

Condylomata acuminata treated with an eighty-per-cent resorcin salve, daily applied, quickly disappear. It is well to apply a five to ten per cent salve for some time afterward to remove the tendency to their redevelopment.

Dr. Ihle does not approve of the application of resorcin to eczema and other inflammatory skin diseases, because of its irritating properties.

Dr. Unna, however, in a pamphlet upon Ichthyol and Resorcin, Hamburg and Leipsic, 1886, recommends a five to ten per cent ointment in the treatment of seborrhœic eczema resulting from alopecia areata, and prefers it to ichthyol or pyrogallic acid.

He mentions as an especial advantage its lack of color and freedom from staining. In psoriasis its action is not so favorable, but for all dry scaly eczemas of the face he recommends it.

On account of the difficulties of diagnosis in skin diseases of the face, he advises that the drug be discontinued the moment it is noticed that no improvement is taking place. In scars or pitting from variola, traumatism, acne, or other cause, and in false keloid he has found it of benefit, but its advantages over ichthyol and other reducing substances lies wholly in the fact that it does not produce discoloration and does not inflame the eyes as does chrysarobin, although under certain circumstances the latter drugs have preference. Dr. Unna declares himself quite convinced that in acute exanthema, and especially in scarlatina and variola, resorcin is destined to play a very important part.

In chronic skin diseases its use must remain limited to external application.

URTICARIA PIGMENTOSA.

In an article on the various forms of urticaria, Dr. Lazansky (*Prager Med. Wochenschr.*, Apr. 21, 1886) devotes some space to the consideration of urticaria pigmentosa.

The peculiarity of this form of chronic urticaria is that, after the disappearance of the wheals, there remains on the site which they occupied a pigmentation which may persist for a long time. Only seventeen cases, according to La-

zansky, have been recorded of this rare disease, and these have been observed for the most part by English authors. Dr. Morrow reported a case in the *Archives of Dermatology*, January, 1879, and Pick (*Prager Zeitsch. f. Heilk.*, II., 1881) and Lewinski (*Virch. Arch.*, 1882, 3 H.) have written upon the subject. The symptoms and course of urticaria perstans pigmentosa are as follows: The affection appears soon after birth, and is therefore to be looked upon as a congenital affection, or one of early infancy; it continues during several years, and the general health is not materially disturbed. There appear almost without prodromata, light-red roundish spots up to five centimetres in diameter, in which a wheal forms, at first white, but afterwards becoming of an intense red color. The wheal disappears, leaving a red spot, which little by little is changed into a brownish-red or light-yellow pigment stain, or the surrounding redness may disappear, while the wheal remains prominent to flatten down later on, but, in this case as well, pigmentation followed its disappearance. There is only slight itching, pricking, or burning, and consequently the results of scratching are seldom seen. Scaling, suppuration, bullæ, and vesicles are not met with.

The whole body, with exception of the neck and face, or only particular regions may be implicated.

The distinction is made between this form and the ordinary urticaria by the long persistence of the wheals and the remaining pigmentation.

Pick and C. Fox have examined these wheals microscopically, and found small hæmorrhagic foci in the skin tissues surrounded by a small cell infiltration of the connective tissue, the papillæ enlarged and the epidermis unchanged.

In Lewinski's case, the pigment deposits were present up to the patient's 9th year; after this, the wheals disappeared without leaving pigment stains behind. The case reported by the author occurred in a female child at the age of 10 months, and was under his observation for three years.

The wheals, at first of an intense red, became paler in a few hours, disappeared in from twenty-four to thirty-six hours, leaving behind a brown-red macule, which would not wholly disappear under pressure of the finger. During the three years of observation, there were eight attacks, each lasting many weeks, the last occurring in the fall of 1885. At the date of report, the child was strong and well as it had always been, and the skin healthy, except that, scattered over the body, and especially the lower extremities, are found round or oval pigment stains, either confluent or discrete. The face, neck, soles, and palms are free. The spots become reddened by rubbing or warming, and dark or sometimes blue in the cold.

There is no itching. During the past year, the eruption has been less frequent and less severe.

ABSORPTION OF FATTY SUBSTANCES.

PROF. UNNA has proven that the more a fatty substance absorbs water the more rapidly it is itself absorbed by the skin.

100 parts of Vaseline are found to absorb.....	4 parts of water.
Of Axunge	15 " "
Of Cod-liver Oil, 70.....	} 32 " "
White Wax, 30.....	
Of Linseed Oil, 70.....	} 48 " "
White Wax, 30.....	
Of Oleic Acid, 70.....	} 60 " "
White Wax, 30.....	
Of Lanolin	105 " "

Items.

GLYCEROLE FOR CUTANEOUS PRURITUS.—

R̄ Acidi Carbolici.....	gtts. xv.
Sodii Biboratis.....	3 grams.
Glycerinæ.....	30 “

M. Apply with a brush over the pruriginous surfaces.—*Le Concours Médical*, No. 18, 1886.

COCAINE IN HERPES ZOSTER.—In a case of herpes zoster, occurring in a child of 7 years, in which all ordinary remedies failed to give relief, Weisenberg applied a five-per-cent solution of cocaine every two hours over the seat of the eruption. That night the child slept quietly, without being awakened every five minutes, as during the previous night, by the burning pain and itching. The following day the pain had ceased, but there remained an itching, which was attributed to the astringent action of the cocaine, which found in the ruptured bullæ an easy mode of penetration to the Malpighian layer. The itching soon disappeared, and at the end of twelve days no trace of the eruption remained. The cocaine, in addition to its anaesthetic properties, was thought to have hastened cicatrization.—*Allg. Med. Central Zeitung*.

SOLUTION FOR VULVAR SYPHILIDES.—

Hydrate of Chloral.....	5 grams.
Tinct. Eucalypti.....	10 “
Aq. destillat.....	100 “

M. f. sol. for the dressing of mucous patches and ulcerous syphilides.—*Jour. de Méd. de Paris*, June 13, 1886.

COCAINE AND BORIC ACID IN GONORRHOEA.—M. Bedoin employs bougies containing ten to twenty centigrams of cocaine in the early stage of gonorrhœa. They were found to have an excellent effect in calming erections. At a later stage he employs bougies containing twenty to twenty-five centigrams of boric acid. The duration of the treatment was from ten to twenty-three days.—*Le Progrès Médical*, June 12, 1886.

APPLICATION FOR WARTS.—The following formula, a modification of that recommended by M. Vigier for corns, is largely used by Vidal:

R̄ Acid. Salicylici.....	1 gram.
Alcohol, 90°.....	1 “
Ether.....	2½ grams
Collodion.....	5 “

M. The solution should be painted over the affected surface each day.—*Jour. de Méd. et de Chirurg.*, June, 1886.

TREATMENT OF ERYTHEMATOUS LUPUS BY THE APPLICATION OF A MIXTURE OF VINEGAR AND YELLOW OF AN EGG.

—Dr. Brocq (*Journal de Médecine de Paris*) calls attention to a practical, convenient, and cheap means of treating erythematous lupus, which the author declares is not inferior in efficacy to any other therapeutic method employed in this disease. Equal parts of the yellow of a fresh egg and ordinary vinegar well beaten up together, and allowed to macerate for twenty-four hours, may be applied in two or more layers over the affected surface. Or a paste made of the yellow of a hard-boiled egg, triturated with vinegar, macerated for several hours, and spread upon a piece of flannel, is applied every night, care being taken that it shall extend beyond the borders of the diseased patch, and the next morning it is to be washed off with black soap.

This procedure does not occasion pain causes only a slight inflammation, is well tolerated by patients, and is followed by a notable improvement. In addition, it does not demand, like scarification or the application of pyroligneous and pyrogallic acids, the surveillance and constant intervention of the physicians. —*Gazette Médicale de Nantes*, No. 4, 1886.

WHITE CLAY IN EPIDIDYMITIS.—According to the *Journal de Méd. de Paris*, March 28, 1886, white clay, such as is used by sculptors, has been used in Russia with much success in many cases of gonorrhoeal epididymitis.

It is made into a soft mass, spread upon a square piece of linen cloth, and applied to the whole scrotum.

Boskine attributes the therapeutic effect of the *argile*, as it is called, to its refrigerating and metallo-therapeutic properties.

AMERICAN DERMATOLOGICAL ASSOCIATION.—The following papers are announced to be read at the Tenth Annual Meeting, to be held at the Indian Harbor Hotel, Greenwich, Conn., August 25, 26, and 27, 1886. Address by the President, Dr. Edward Wigglesworth.—1. Report of a Case of Lymphadenoma (Mycosis Fongoïde), and Autopsy, by Dr. G. H. Fox.—2. Note Relative to the Bullous Eruption Occurring after Ingestion of Iodine Compounds, by Dr. J. N. Hyde.—3. Erythema Syphiliticum, by Dr. E. B. Bronson.—4. "Rötheln," by Dr. I. E. Atkinson.—5. Precocious Gummata, by Dr. R. W. Taylor.—6. Clinical Notes on Scabies, by Dr. F. B. Greenough.—7. Clinical Observations regarding the Value of Resorcin, Ichthyol, and Lanolin in Cutaneous Diseases, by Dr. H. W. Stelwagon.—8. Trophoneurosis of the Skin, by Dr. G. H. Tilden.—9. Native Plants Injurious to the Skin, by Dr. J. C. White.—10. Erythema Multiforme and its Allied Affections, by Dr. A. Van Harlingen.—11. A Few Additional Notes on Psoriasis, by Dr. F. B. Greenough.—12. Report of a Case of Exfoliative Dermatitis, by Dr. W. A. Hardaway.—13. A Clinical Study of Scleroderma, by Dr. G. E. Graham.—14. A Case of Carcinoma Cutis, by Dr. L. N. Denslow.—15. Keratosis Follicularis, by Dr. P. A. Morrow.—16. Surgical and Obstetrical Scarlatina, by Dr. I. E. Atkinson.—17. Notes on Drugs, by Dr. H. G. Piffard.—18. Two Cases of Dermatitis Herpetiformis, by Dr. A. Van Harlingen.—19. Remarks and Queries on, and as to Relative Frequency of, Moles and their Pathological Changes on the Face and Head, by Dr. S. Sherwell.—20. An Unusual Form of Tuberculosis of the Skin, by Dr. G. H. Tilden.

G. H. TILDEN, M.D., *Secretary*.

EDWARD WIGGLESWORTH, M.D., *President*.

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Original Communications.

KERATOSIS FOLLICULARIS, ASSOCIATED WITH FISSURING OF THE
TONGUE AND LEUKOPLAKIA BUCCALIS.¹

BY

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THE comparative rarity of this form of follicular disorder, its unusual development, and its association with peculiar mucous membrane changes in a case which recently came under my observation, have led me to believe that a report of its more characteristic clinical features may not prove uninteresting to the members of this Association.

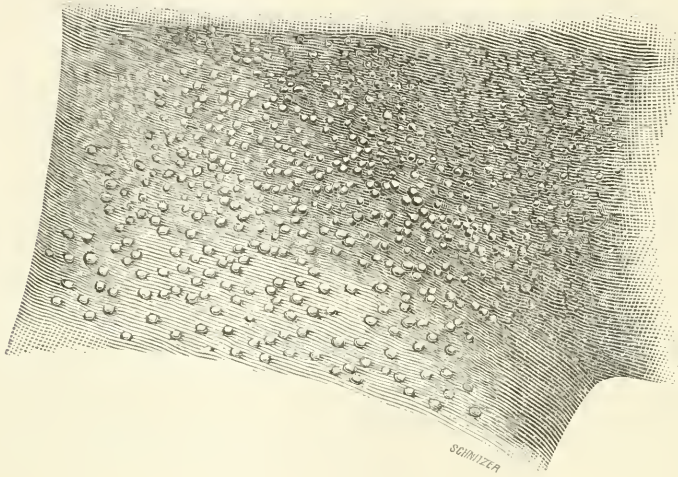
The patient, Chas. Olsen, æt. 21, a sailor by occupation, presented himself at my class at the Bellevue Out-Door Poor in December, 1885, with the following history:

About five years ago, soon after beginning his seafaring life, he observed a number of blackish protruding points upon the backs of his hands, some of which he occasionally squeezed out. Soon afterward, he observed the same condition of the skin of the neck, arms, and other portions of the body. This peculiar condition has continued ever since, with a very noticeable improvement in the intervals of his voyages, when he is on land, and a marked aggravation when he is at sea.

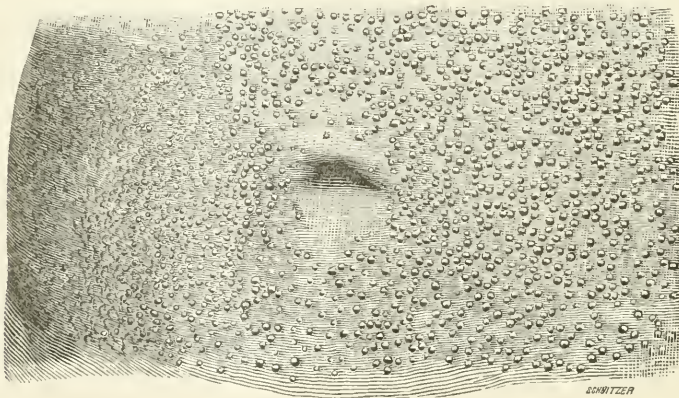
When the patient was stripped for examination, there was observed a

¹ Read at the Tenth Annual Meeting of the American Dermatological Association.

grayish or brownish discoloration of the surface, the pigmentation being most marked upon the abdomen, over the deltoid regions, and the outer aspect of the thighs. Upon passing the hand over the surface, instead of the soft, supple feel of normal skin, there was experienced a harsh,



rough sensation, comparable to that communicated by a calf's tongue. The entire surface of the body, with the exception of the face, palms, and soles, was found to be the seat of follicular disorder, the specific characters of which may thus be described: The ducts of the sebaceous



glands project above the niveau, and are occupied by round or comedo-like substances, grayish or dark in color, some of which protrude in the shape of spinous prolongations, more or less prominent. Many of these spinous projections are one-quarter to one-half inch in length. They

are longer and more abundantly present over the back of the neck, the abdomen, posterior surfaces of arms, thighs, and legs. From many of the follicles, especially over the abdomen, small white hairs protrude.

The comedos, when pressed out, present a grayish, horny, somewhat glistening appearance; they are hard and perfectly dry, and, when thrown upon a sheet of paper, rattle like dried peas. If the process of extrusion was carefully conducted, the hard, more compact part of the comedo was found to be continuous with a stringy, adhesive substance, which dipped deeply down into the follicle, and which could be drawn out some distance. After expression of the contents of the follicles, the ducts still remained dilated and projecting. I removed quite a number of the comedos from a limited area of skin, and the patulous orifices were quite suggestive of the punched up holes of a nutmeg grater. In the photographs of a portion of the neck and the abdomen from which the illustrations are made, the dilated and projecting excretory ducts are admirably shown. None of the follicles show evidences of irritative or suppurative action. No matter how large the comedos, or how long persistent, their presence does not occasion the slightest inflammatory reaction.

Upon the anterior surface of left leg just below the knee, there were five or six small, rounded, depressed cicatrices; on the right leg, there were two or three similar lesions of which the patient could give no account. Over the popliteal spaces of both legs there was a number of dry crusts or scabs which were presumably the result of wounding the skin in scratching, although the patient was quite positive that he never experienced an itching sensation on any part of the body.

Upon examination of the mouth, the mucous membrane over soft palate and roof of the mouth was seen to be studded with innumerable minute brownish spots, apparently indented or depressed, rather than elevated, although to the touch the surface feels perfectly smooth.

The tongue was found to be large, somewhat thickened and flabby, and rough to the touch. The surface was white and pasty, and deeply fissured, the fissures extending down into the submucous tissues. Some of them were veritable clefts, one-eighth to one-quarter of an inch in depth, presenting a certain branched arrangement. The buccal mucous membrane presented an opaline or bluish-white appearance, is thickened and raised in many places, forming distinct plaques which are superficially fissured. This leucomatous condition is especially noticeable at the commissures of the lips, and extending backward along the line formed by the junction of the teeth when closed.

The patient states that his tongue has been "white and a little sore" ever since he can remember. The absence of irritation or marked sensitiveness of the fissured organ was quite a noticeable feature. He suffers

no pain or inconvenience, except when using condiments, especially salty food.

He also has a conjunctivitis and a slight kerato-iritis, for which he is being treated at the Eye and Ear Infirmary. Their possible syphilitic origin was suspected, but the history would seem to negative this assumption. He states that he never had a venereal disease until a little over a year ago (in November, 1884), when ashore in Philadelphia, he stayed with a woman. Before his vessel reached Boston, four days later, he observed upon his penis a small sore, which healed up without treatment in the course of a week or two. He has never had any eruption or other evidence of the disease.

The suspected specific nature of the buccal leucoplakia and fissuring of the tongue was also disproved by the fact of their development several years previous to the occurrence of any venereal disease. Their association with the peculiar changes in the follicular apparatus of the skin must be regarded in the light of an accidental complication, since, irrespective of the patient's history, the objective appearances presented by the tongue and buccal mucous membrane were entirely dissimilar to the ordinary manifestations of the syphilitic diathesis.

The most interesting clinical feature of this case was the implication of almost the entire follicular apparatus of the skin in a morbid process which had resulted in a dilatation and projection of the excretory ducts, and the presence of comedo-like plugs, which were altered in character and exaggerated in development.

Examination of the contents of the follicles showed a deficiency of fatty matter, and a marked increase in the corneous elements. They were dry, hard, and of horny consistence.

The cause of the cornification must be sought for in some structural peculiarity or lesion of the sebaceous glands, permitting a premature exfoliation of the epithelium before fatty transformation of the cells was complete. Associated with this vitiated secretion, there was probably an atony of the glands, or deficiency of excretory power, resulting in long retention of the sebaceous matter in the excretory ducts. Owing to this obstruction, desiccation and solidification of the mass took place, and in the process of excretion, the hard, cornified contents were pushed up above the surface of the skin in the form of elongated sebaceous plugs, which preserved the exact shape or mould of the ducts.

The sebaceous plugs were evidently of the nature of comedos differing from ordinary comedos in their consistency, their exaggerated development, and their generalization over parts of the body where comedos are not commonly met with.

This form of follicular disorder also presents certain analogies with a variety of sebaceous disease characterized by a copious secretion of seba-

aceous matter which concretes upon the surface, forming an incrustation of dry hard scales. In both, the excretory ducts are dilated and patent, in both there is a vitiated secretion, which assumes a hard horny consistence. It is to be differentiated from ichthyosis sebacea by the fact that in the former there is an atony of the glands with deficient secretion, in the latter there is a hyperactivity of the glands with excessive secretion. In one case keratification takes place within the interior of the canal, in the other it is secondary, the hard cornified character of the incrustation being due to desiccation of the sebaceous fluid after its escape from the excretory ducts.

So far as I have been able to ascertain, the literature of this dermatosis is comparatively limited and somewhat confusing, since there seems to be no uniformity in the nomenclature employed by different authorities. Under the term *acné sebacée cornée*, Guibout¹ describes a disorder of the sebaceous follicles, the clinical features of which closely correspond to those presented by my own case. He says: "In this form the sebaceous matter, secreted in great abundance, is retained in the excretory ducts of the sebaceous glands, it there hardens and takes on the consistence of horn. The rounded cylindrical or thread-like form is given to it by the calibre of the excretory canal, in the interior of which it had been retained, hardened, and as if moulded. In elevating itself above the niveau of the skin in the form of projections more or less prominent, the sebaceous matter forms so many hard prickly and horny points which give to the hand passed over the surface the dry pricking sensation which it experiences from the skin of a reptile or fish."

Evidently Guibout had never met with a case in which the follicula, disorder was so generalized as in the one which came under my observation, since he mentions as one of the differential features of *acné sebacée cornée* that it is scarcely ever met with except upon the brow, cheeks, and nose. In my case, it is worthy of note that these parts were entirely exempt from any manifestation of the disease. The objection to his designation is that the employment of the term *acne* is by modern authorities restricted to sebaceous disorders in which an inflammatory element is present.

In the volume on "Diseases of the Skin" (Ziemssen's Cyclopedia), Lesser refers to this disease, which he says is exceedingly rare, under the name of *ichthyosis follicularis*. In order that there may be no question of its identity with the disease under consideration, I quote his description of what he characterizes as an exquisite example of this variety of *ichthyosis*.

The patient was a boy 6 years of age. "Over the extensor surfaces of the extremities, most markedly on the wrist and ankle, besides on the

¹ "Nouv. Leçons Cliniques sur les Maladies de la Peau," Paris, 1879.

face over the brow, nose, and auricular edges, thin compact scaly columns, even as long as a millimetre, whitish or grayish in color, are seen projecting from a large number of follicles. The flexor surfaces of the trunk are very much less affected, and the palms and soles are entirely free. On the scalp which centrally has a few isolated hairs and peripherally a scanty growth, these epidermal spines may be seen projecting from a number of hair follicles. The eyebrows are entirely wanting, and in this region the affection is very marked. Passing the finger over the diseased parts produces a sensation like that caused by the prickly surface of a rose leaf."

The use of the term *ichthyosis* is objectionable, since it suggests a disease which is entirely different in its nature, its mode of development and its objective symptoms. *Ichthyosis* is recognized as a congenital malformation of the skin, characterized by an anomalous and devious development of the epidermis, which is modified in its arrangement and altered in character; the disease under consideration consists essentially in an affection of the sebaceous glands, for while the hair glands are to a certain extent implicated in the morbid process, the former play the principal part in the production of the peculiar phenomena.

I have selected the term *keratosis follicularis* as more correctly expressing the pathological condition present, as well as indicating the anatomical seat of the disorder. If the morbid changes were limited to the sebaceous glands, *keratosis sebacea* would perhaps cover the condition, but since the annex glands of the hair are also involved, the more comprehensive qualifying adjective, which includes both groups of glands, is to be preferred.

Appended will be found the results of the microscopical examination of sections of the lesions, which were made by my friend, Dr. A. R. Robinson.

Anatomy.—A single, markedly elevated and well-developed lesion from the abdomen, and two closely situated and smaller lesions from the back were removed, and hardened by putting them first in Miller's liquid and afterwards in alcohol.

In Fig. 1 is shown, under a low power, a section through the central part of the single lesion. The corneous layer is thicker than normal, the rete is unchanged, and the corium presents nothing abnormal except a slight dilatation of some of the blood-vessels in the immediate neighborhood of the papule. The lesion (papule) itself presented the following characters: The part above the general surface (*d*) consisted of epithelial cells in various stages of degeneration, although the majority resembled those of the upper corneous layer of the skin or the epithelial cells of the funnel-shaped orifice of a hair follicle. The remainder of the papule—the part beneath the general surface—consisted of fatty and corneous

degenerated epithelium, epithelial and fatty débris, and portions of hair shafts, all lying in a greatly distended sebaceous gland. The outer layers of epithelial cells of the sebaceous gland were flattened against the basement membrane, and the more internal layers were also flattened and showed no signs of undergoing the normal fatty transformation.

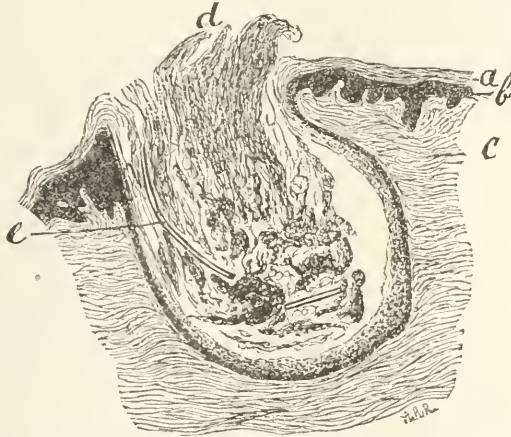


FIG. 1.—Section of a solitary well-developed papule. *a*, corneous layer; *b*, rete layer; *c*, corium; *d*, central elevated part of lesion; *e*, fragment of hair-shaft.

That the lesion consisted in changes occurring principally in the sebaceous gland was shown by the nature of the contents of the papule, its situation or limitation to the upper part of the corium; the hair-follicle extending much deeper than the lesion, and by the globular shape. If it was a lesion specially affecting the hair-follicle, it would have extended to the subcutaneous tissue, it would not have had such a rounded form, and the contents would not have consisted of so many broken-down epithelial cells. It resembled the appearances found in many comedones, except that I have never seen so many epithelial cells in the sebaceous plug as is present in this case; that is, in this lesion there is a keratosis combined with obstruction and dilatation of the gland.

In Fig. 2, which represents a section from the two closely situated and smaller lesions, the corneous layer is seen to be much thickened in the neighborhood of hair-follicles, and especially in the follicle area. At *f* the epithelial cells are shown in greatly increased numbers. This portion of the section corresponds to the funnel-shaped part of the hair-follicle, hence the occurrence of epithelial cells so low down in the section.

At a distance from the papule the corneous layer was normal. The rete was normal except that there was a marked increase in the amount of pigment over the normal in the lower rows of rete cells. This increase

is represented in the drawing. The corium was normal, except that the blood-vessels were somewhat dilated, and there were quite a number of round cells in the perivascular area; signs of slight inflammatory changes, due probably to irritation from pressure exercised by the papules. The apex of one of the papules corresponds to *d*, and is shown to be in a hair-shaft area, as the hair (*e*) passes through the centre of the elevated mass. As in the previous lesion, the elevated part consists almost entirely of epithelial cells, with their origin in this case from the corneous layer and corresponding part of the hair-follicle orifice. Within the skin

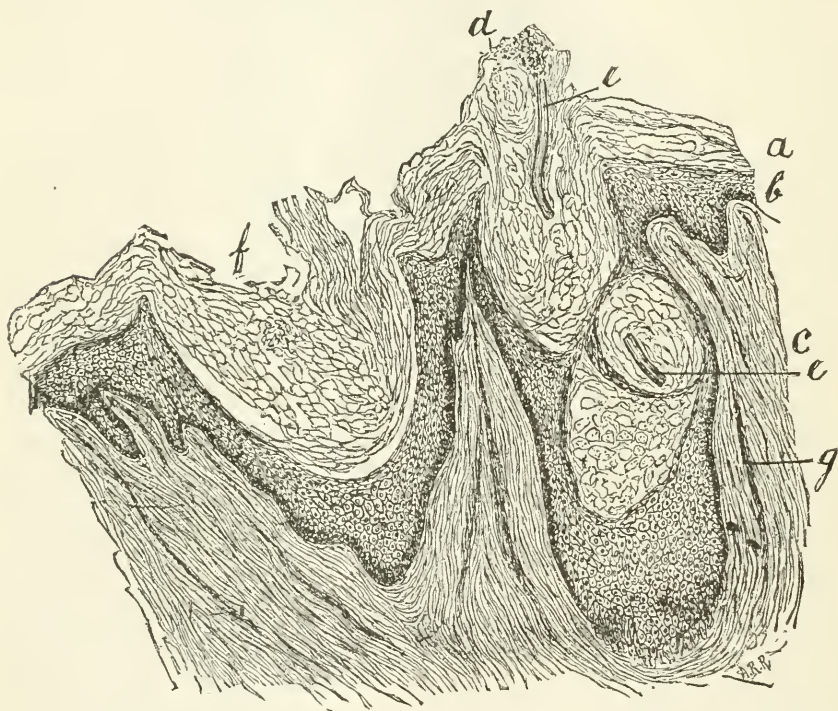


FIG. 2.—Section of two small papules. *a*, corneous layer; *b*, rete mucosum; *c*, corium; *d*, apex of papule; *e*, hair shaft; *f*, hair-follicle exit area; *g*, blood-vessels.

the papule is made up of similar epithelial cells, and lower down of cells from the sebaceous gland. In this drawing the sebaceous gland may be considered to begin about on a level with *e*.

This drawing, which represents a more recent lesion than Fig. 1, shows the pathological condition to be essentially one affecting the corneous layer and similar cells, and consists in a hyperplasia of that structure. The changes in the sebaceous glands corresponding to the comedo condition are probably secondary, and consequently the affection might be

called a keratosis affecting the follicles. I believe many of the lesions of ordinary comedo arise in the same manner, that is, primarily as a keratosis, causing obstruction to the expulsion of the sebaceous gland contents.

DISEASES OF THE SKIN IN THE SUBJECTS OF GOUT. A REPORT OF THREE CASES; WITH REMARKS.¹

BY

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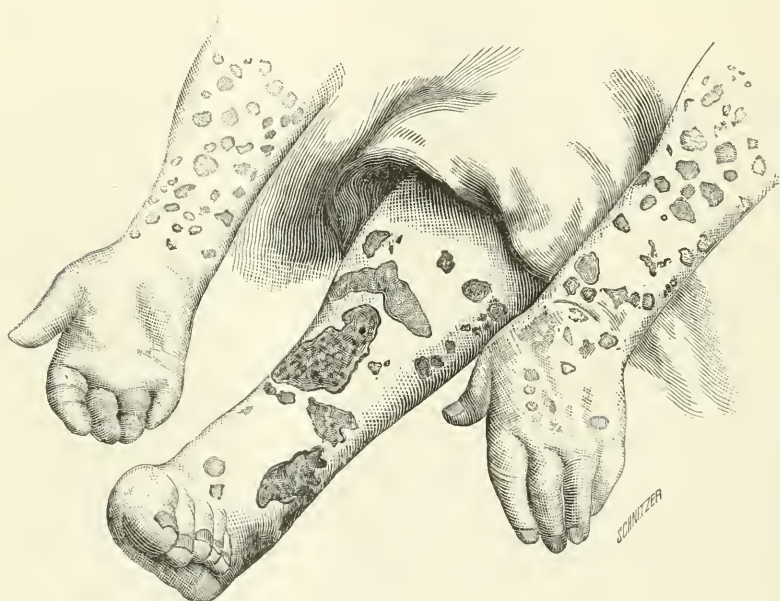
CASE I.—Mary B., aged 62, a native of Ireland, married, was admitted an out-patient at the Clinic for Skin Diseases November 11, 1883. The family history shows her immediate ancestors to have been free from gout, rheumatism, or any protracted illness. A brother of the patient died two years ago with symptoms identical with that of the present case. At the age of 27, she came to America, having previously enjoyed robust health; soon after her arrival, she suffered from intermittent fever, which continued three years. After this she had good health until the menopause at the age of 46, and bore five children, four of whom are now living. At this time she suffered from what was called rheumatism; she said she was confined to her bed with an inflammation of the small joints, which first appeared in the ball of the great toe; paroxysms of pain came on at night, at which time the weight of the bed clothing could not be borne; these paroxysms have recurred from time to time since. At the age of 55, an eruption broke out on the lower part of the legs, in appearance similar to that which now covers the forearms, as shown in the plate; in the course of a twelvemonth this resulted in two ulcers. I could obtain no history of syphilis, although she had been under syphilitic treatment.

On admission, she complained of pain in her feet and difficulty in moving her fingers. The pain in her feet prevented sleep, not in recurring paroxysms, as at first, but continuously; the parts could be handled without special discomfort. The face had a puffy appearance, best marked in the lower lids, and the skin was of a pale, waxen hue. The forearms and legs were covered with an eruption of a dark-reddish color, slightly scaly, moist only when scratched, itching moderate. On the left leg are two irregular shaped ulcers as herein shown, on the right there are three cicatrices the size of a quarter of a dollar. The veins of the leg are of normal size. The joints of the foot are ankylosed, those of the hand markedly stiffened; they are enlarged by bony conerctions, especially prominent at the metatarso-phalangeal joint of the great toe. The urine at the time of passing was acid; specific gravity, average in six days, 1,028, slightly albuminous; passed a small quantity; bowels gener-

¹ Read before the Ohio State Medical Society, June 4, 1886.

ally open; appetite poor; tongue furred. Serum from a blister, treated with acetic acid and evaporated, showed uric-acid crystals adhering to a cotton fibre which had been immersed in the liquid. She said since coming to this country beer had not agreed with her, and ale made her chilly; she had never used beer or spirits to any extent. She made use of meat twice a day.

The treatment adopted was wine of colchicum, ten minims; liquor of potassium, ten minims; and infusion of gentian twenty minutes after each meal. She was directed to keep the legs elevated and the ulcers covered with mineral earth. At the end of a fortnight she returned, the eruption had improved, and the ulcers gave less inconvenience. On account of its purgative effect, the colchicum was discontinued, and, considering her advanced age and more advanced state of structural dis-



solution, soothing and tonic measures alone were employed. At the present writing, she is free from the eruption, and the ulcers have diminished fully one-half; in other respects, her condition remains about the same.

CASE II.—Sarah B., aged 21, single, daughter of the patient preceding, applied for treatment at the College Clinic for Skin Diseases October 12, 1885. She had enjoyed robust health up to the age of 18, although her menstruation had been irregular since it first appeared, at the age of 14. Three years ago she had a reddish eruption on her forearms and legs, very itchy and moist; this had disappeared and returned several times. She had suffered for one year or two with muscular rheumatism. On admission, she appeared well nourished, and was well developed. She complained of an eruption which was very itchy. It was distributed discretely over the body; the flexor and extensor surfaces

were equally affected, likewise the exposed and protected parts. It was of a dark-reddish color, slightly scaly, more so on the trunk than on the extremities, whereas on the latter it was more moist. It seemed a hybrid between psoriasis and eczema. Her urine was acid at different times, and the specific gravity averaged 1.018. Upon standing, it threw down a free deposit of urates; it contained also uric acid, urea, and oxalate of lime; she passed a free quantity. Serum from a blister tested with uric acid gave a negative result; the saliva was acid; appetite good; bowels constipated.

She was given blue mass, four grains, to be repeated at the end of a week, and Rochelle salts in hot water before breakfast. For local treatment, tar ointment was employed. She made a speedy recovery, and up to the present writing remains well.

CASE III.—John M., aged 55, married, an Englishman by birth, was admitted into St. Elexis Hospital February 4, 1886. The family history as related by the patient is good. John M. set out in life as a sailor, which vocation he followed until 30 years of age, when he had the scurvy, and was confined in a hospital in Liverpool, whereupon he quit the high seas, and adopted the painter's craft, which vocation he has followed to the present time. He is very susceptible to the influence of lead, and has had lead colic several times. At the age of 33, he had an eruption which covered the entire body; it appeared quite suddenly, was very scaly, and the itching annoyed him at night. This attack left him in a few weeks, but similar attacks have returned with increasing frequency, and of late they have been almost continuous. When admitted, he complained of general debility, sciatic pains, and an eruption which was moderately itchy. The eruption covered the entire surface of the body, the epidermis came off in large flakes the size of the palm, the skin underlying was moist. His appearance was that of advanced senility; anæmic with arcus senilis, muscular tremors, and an atheromatous condition of the arteries. Appetite poor, and bowels habitually constipated. Urine scanty; the measurement for three days gave twelve ounces *per diem*, of high color, acid reaction, specific gravity 1.030, albuminous; upon standing, deposited the urates abundantly; oxalate of lime and granular casts were also present. Serum from a blister contained uric-acid crystals.

The patient was given a diet of milk, a small quantity of stale bread, green vegetables *ad libitum*, and fresh mutton or beef twice a day, with lemon juice in lieu of tea or coffee. Alkalies and vegetable bitters were given as a medicament a short time after meals, and Rochelle salts in hot water upon rising in the morning. Locally, alkaline baths, followed with tar ointment. With this, he is improving, and has resumed work. The case is still under observation.

In selecting these cases the primary object is to illustrate certain salient features in the genesis of gout as a basis for considering the cutaneous diseases arising therefrom, this would be unnecessary were it not that many competent observers do not recognize the influence of the gouty state in the evolution of diseases of the skin; secondly, to point out the distinguishing features of the lesions themselves; and finally, to outline the treatment best suited for them.

Without discussing the etiology of gout, which would be foreign to the scope of this paper, we shall assume the condition to arise from an imperfect oxidation of the albuminoid substances of the food which enter the blood in the form of uric acid, lactic acid, oxalic acid, kreatin, and kreatinin. These substances represent the stages or by-products of assimilation and disassimilation, the conversion of food into tissue and again of tissue into excrement, which is so aptly expressed by Piffard.¹ Further, this suboxidation depends for the most part on derangements of the liver² and spleen;³ while elimination takes place through the kidneys, bowels, skin, and pulmonary mucous membrane. From this we may readily conclude, *a priori*, that these improperly prepared and insoluble products will, if continued, induce in these several channels of excretion pathological states, of which those of the skin are herein considered. In the history of the first case, malarial influence seems to have been the starting-point of a succeeding train of woes, but whether or not malarial poisoning, with its well-known influence on the liver and spleen, should be regarded as the *fons et origo* of the subsequent lithæmia, opinions may differ. Whatever the cause, the diathesis seems to have been acquired.

In the second case we have the outburst of a transmitted diathesis: the patient, the youngest of five children, born when the maternal organization had already acquired the taint from which both mother and daughter now suffer. It appeared, too, in early life, when functional activity is at its height; when the system, unencumbered by inherited vice, would surmount extraneous influences under which it now gives way.

The third case is representative of the class spoken of by Roose,⁴ of which he says "the injection of lead into the system produces an excess of uric acid in the blood, and the subjects of gout are easily poisoned by lead. Here we have poisoning preceded by the scurvy, followed by a cutaneous inflammation, which recurs from time to time, and which is associated with an excess of uric acid in the blood, three conditions closely allied, if not dependent upon the same morbid influence."⁵ But the practical question which interests us to-day is, how are the eruptions which arise from lithæmia to be known, what are their distinguishing points, what are their salient features? Murchison says, anatomically there is nothing to distinguish these eruptions from those due to other constitutional states.⁶ Tilbury Fox refers to eczema as the progeny of

¹ "Materia Med. and Ther. of Skin Diseases," 1881, page 131.

² Murchison, "Functional Derangements of the Liver," 1879.

³ Parks, *Lancet*, 1871, vol. I., page 467.

⁴ "Gout and its Relation to Diseases of the Liver and Kidneys," 1885.

⁵ Ralfe, "Clinical Chemistry," 1883, page 290.

⁶ "Functional Derangements of the Liver," 1879, page 150.

gout; and Liveing described gouty psoriasis. With due respect, I venture to be of opinion that objectively, if not anatomically, these eruptions have peculiarities which may be best described as a hybrid between eczema and psoriasis, retaining points of semblance to each, yet so blended as to form a type which differs from them both. Of the lithæmic eruptions which have come under my notice, the following features were most noteworthy: First. They were scaly; the scales were not adherent nor heaped up, neither were they of a silvery color, as in psoriasis; when detached they left an oozing surface. Second. The color was reddish and closely resembled a syphilide. Third. There was a tendency to a symmetrical distribution. Fourth. They were met with in adults usually after forty-five, except when inherited. Fifth. They were accompanied by other evidences of lithæmia. Sixth. They are prone to return.

Let me conclude by giving a few suggestions as to the treatment which has proved most useful in this class of skin diseases. The diet is of primary import and does not differ from that employed in the treatment of gout. In this there can be no fixed rules; some require more than their accustomed fare, while others must be curtailed to a Lenten simplicity. All have special idiosyncrasies which are imperative. The things generally to be interdicted are: rhubarb, strawberries, apples, pickles, sugar and acids, except in moderation; eggs, lobsters, and fats are generally ill borne. Malt liquors, port wine, and champagne should be especially prohibited, and the free use of water should with equal emphasis be encouraged. After this the digestion should receive attention; first, the hygienic laws pertaining thereto should be enforced, and, if necessary, vegetable bitters, pepsin, or pancreatin may be given as indicated. Next in importance to the diet is fresh air and exercise. The special medication embraces the alkalies, colchicum, and in exceptional cases the mineral acids. Of the first, the liquor of potassium, ten to fifteen minims well diluted, taken twenty to thirty minutes after meals, as suggested to the writer by Dr. Liveing, of London, is of benefit in a large number of cases. At times Rochelle salts, Carlsbad salts, or the mineral waters are required; they should be taken before breakfast, the former well diluted in hot water. Again, the lithia salts act best; this has been noted when the eruption was accompanied by muscular rheumatism. My very limited experience with colchicum is not favorable to its use. When benefit was derived it seemed to depend on its purgative effect. Local treatment is of little importance except to mitigate suffering. The alkaline baths, preparations of tar, and ammoniated mercury comprise the means most in vogue and best suited to this end.

LANOLIN.

BY

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Late Assistant to Dr. T. Colcott Fox, London, Eng.; Memb. Brit. Med. Association.

LANOLIN has been recently introduced to the notice of the medical profession by Dr. Oscar Liebreich, of Berlin.

This substance is obtained from the alkaline water washings of sheep's wool; it is a fatty body consisting of fat acids and cholesterin in varying proportions; these substances are mixed with a certain percentage of water, and a smooth unctuous mass results.

Lanolin is at present being largely used as a basis for ointments both in this country and in Europe, and very encouraging results are reported by many who have used it, but it will be necessary to give it further trial before its proper sphere of usefulness is ascertained.

Since lanolin is rapidly absorbed by the skin, lard or cerate should be added in small proportion, to prevent its too rapid absorption where this effect is not required.

Lanolin can be readily rubbed into the skin without producing any irritation, and hence is very serviceable in dermatitis of delicate skins.

Medicinal substances combined with lanolin are said to be more readily absorbed when applied to the skin than when a different ointment base is used. Lanolin is too sticky a substance to be used alone, and hence Liebreich suggests that some substance be added to make it more pliant.

He has experimented with various substances, as oils, vaseline, paraffin ointment, glycerin, and fat, and of these he has found the fat to be preferable because, unlike the others, it does not interfere with the absorbing properties of the lanolin.

Lanolin is capable of taking up more water than other fatty bodies; it mixes with more than one hundred per cent of water, forming a light-yellow, plastic salve.

Deiterich states that vaseline takes up 4 parts of water, lard 15, benzoinated lard 17, and lanolin 105 parts. Lanolin being a neutral base will not decompose any medicament which may be added to it.

Dr. Liebreich, whose experience with the drug is limited, has nevertheless obtained very promising results from its use; others who have used it speak very highly of it. Dr. Liebreich states that corrosive sublimate salve (1:1,000) made with lanolin, if rubbed into the skin, is so rapidly absorbed that the characteristic metallic taste due to the absorption of the mercury will be noticed in a short time. Lanolin being so rapidly

absorbed by the skin, it is preferable to mix a certain per cent of some fatty substance with it, so that when rubbed into the skin for any length of time it will not leave the skin dry, as would be the case were lanolin alone used.

Dr. Lassar, who has used it in a large number of cases, says that it does not irritate the skin and is recommended in massage. He uses a twenty-five per cent chrysarobin-lanolin ointment in cases of psoriasis with good success, the psoriatic patches quickly disappearing and without causing irritation of the skin.

I will now briefly mention a few cases in illustration of the uses of lanolin.

Mrs. C., aged 30, was seen by me in May last; she said she was subject to psoriasis more or less for the past ten years, the eruption varying in intensity and duration, but in May of the present year the disease suddenly developed into an extensive eruption extending over the face, chest, back, and limbs; it was in fact a typical case of universal psoriasis. The patient was covered with small scaly patches from head to foot. She said that her father, who is about sixty years old, was also troubled with psoriasis, but there has been no appearance of the disease for a long time.

She has three brothers and two sisters, two of the former and one of the latter persons being affected more or less with the same disease, though in a very light form.

The treatment consisted of alkaline baths which were afterwards followed by ointments. To one limb I applied an ointment made up of 30 grains of pyrogallie acid and 15 grains of salicylic acid to the ounce each of lanolin and benzoinated lard.

This ointment caused no irritation, the patient returning in one week with slight improvement.

Thinking that a stronger ointment might be more effective, I added ten grains of the former and five grains of the latter acid and saw my patient again in a few days and found great improvement in the disease, which I attributed to the stronger ointment; this produced a very slight irritation which was readily soothed by a bland application. This ointment was used on the limb of the right side only. Over the rest of the body except the face I used the following ointment (Liebreich): \mathcal{R} Chrysarobini, partes 20; Adipis, partes 10; Lanolini, partes 80. This ointment produced a marked improvement, so that in one week the portions of the body to which it was applied were greatly improved, and in three weeks the scalliness had entirely disappeared, leaving no trace of the eruption except some brown pigmentary stains, probably due to chrysophanic acid, which entirely disappeared. For the eruption on the face I used: \mathcal{R} Hydrargyri præcipitati albi, partes 10; Adipis, partes, 10; Lanolini, partes 80. She was given arsenic internally.

Several other cases of psoriasis were treated similar to this case, with like results, the period of treatment being in some cases longer than in the case related.

In the case of a child, aged 13, who had a profuse form of psoriasis

guttata on the arms and legs, I used the following ointment: \mathcal{R} Naphthol, gr. iij.; Adipis, 3 ij.; Lanolin, \mathfrak{z} i.

This acted very well, except that it caused a very slight irritation, which was removed by a soothing ointment. Two drops of liquor arsenicalis were given three times a day.

A child 3 years old was brought to me about the middle of May last with an angry outbreak of eczema of the face and forehead. The mother said the child's face was in this condition for about a week before coming to my office. In addition to the facial eczema, the arms were also affected with eczema rubrum, which the mother said appeared after that on the face had been well out; the child's face was in a similar condition when eighteen months old.

Both arms of the child being affected, I thought it a good opportunity to test the efficacy of lanolin.

Accordingly on the right arm I applied, spread on lint, the following ointment: \mathcal{R} Zinci oxidi, partes 10; Adipis, partes 10; Lanolini, partes 80.

On the left arm I used oxide-of-zinc ointment. The condition of each arm, as regards disease, was similar, so that one arm cannot be considered worse than the other.

I personally attended to this case, and the arm on which the lanolin-zinc ointment was used healed before the left arm on which the zinc ointment was used. Whether this effect was due to the lanolin I am not prepared to say, but certain it is that the lanolin acted quicker in this case than the zinc ointment.

I also used lanolin-zinc ointment on the face, and it healed quicker than a similar case in which I used twenty to forty grains of oleate of zinc to the ounce of vaseline.

In April last, T. M., aged 25, a painter, consulted me on account of a dark discoloration covering the entire back and chest down to a level with the umbilicus. The disease was also present on the arm, extending below the elbow. The amount of desquamation was very slight; a microscopical examination of a few scales scraped from the diseased surface of the trunk revealed the presence of the microsporon furfur, thus proving the disease to be tinea versicolor.

In this case I prescribed an ointment as follows: \mathcal{R} Sodii hyposulphitis, 3 ij.; Adipis, 3 ij.; Lanolini, \mathfrak{z} i. This ointment was very effective, removing the disease in a short time.

In the case of a child, 6 years of age, with enlarged glands under the jaw, I prescribed the iodide-of-lead ointment. I saw the case in a week, scarcely any improvement having taken place.

I then prescribed iodine, ten grains to the ounce of lanolin, with a little lard. I saw the child in ten days, and, much to my surprise, found the swelling had almost entirely disappeared. I have used this iodine-lanolin in a few similar cases, with very satisfactory results.

I have used lanolin in several cases of chapped hands and I am very well pleased with its action, a few cases being cured by a single inunction. In this case I think the lanolin alone is preferable to use, as it is rapidly incorporated into the skin. A few minims of oil of lavender added to the lanolin will give it an agreeable odor.

I have also used lanolin in cases of acne, eczema, and ringworm; in a few cases, benefit was derived; in others, no effect other than that produced by other ointments was obtained.

In most of the cases in which I have used lanolin, I have obtained better results than from other ointments. From personal experiments with lanolin I am satisfied that, when rubbed into the skin, it disappears almost immediately. If other fats are rubbed in side by side with lanolin, the skin to which lanolin is applied becomes turgid and less supple than the part to which fats were rubbed in.

Experiments on the skin of the cadaver with cinnabar-lanolin and cinnabar-fat ointments have showed by microscopical examination that the lanolin ointment penetrated deeper than other fats used as an ointment base.

Lassar finds that lanolin is very well tolerated, especially in cases where, from the nature of the disease, the skin is irritable. He recommends it highly as a base for ointments where deep penetration is desired, as in psoriasis, tinea tonsurans, and syphilis.

To produce suppleness of the skin, he mixes it with twenty per cent of vaseline or cosmoline. In the inunction treatment of syphilis, Dr. Lassar considers the lanolin an improvement. Fränkel finds that lanolin preparations, when applied to the mucous membranes, prevent crust-formation and slightly diminish the secretion.

Lassar reports favorable results from the use of lanolin in eczema, impetigo contagiosa, and pityriasis versicolor.

A very obstinate case of the last-named disease was quickly relieved with three inunctions of an ointment composed of: Lanolini, partes 88; Sulph. præcip., partes 10; Acidi salicylici, partes 2. In chronic cases of scabies and sycosis, he recommends the following ointment as useful: R Naphthol, 5 to 10 parts; Saponis viridis, cretæ albi, sulphur. præcipitati, lanolini, āā 25 parts. Ihle, of Leipzig, recommends a five to ten per cent resorcin-lanolin salve as a good application in cases of sycosis.

Further experiments are necessary before the value of lanolin can be thoroughly ascertained.

ELEPHANTIASIS ARABUM IN CHILDREN.

ACCORDING to the *Revue Mensuelle des Maladies de l'enfance*, March, 1886, Dr. Moncorvo has met with elephantiasis arabum in young children. The author cites a series of interesting personal observations which would go to show that, contrary to the generally accepted belief, this disease is met with in quite young persons, and is not confined to tropical countries, but is observed as well in the temperate climes of Europe.

LATENT SYPHILIS—A CASE.

BY

E. R. PALMER, M.D.,

Prof. of Physiology and Physical Diagnosis, University of Louisville.

IN April, 1883, A. B., aged 22, blonde, a commercial traveller, contracted three sores on the mucoid surface of the prepuce. They were shown to several doctors in different towns, cauterized each time, and each time pronounced non-infecting sores. On July 17 he consulted me. The three sores had coalesced, were suppurating freely, and notwithstanding past treatment were not indurated. A guarded prognosis was given, the sores treated with cotton dressing and diluted Labarraque's solution, and in a few days the patient discharged well, with the injunction to watch himself carefully, and to report to me from time to time. No internal treatment was given, and though examined frequently for the next six months, no constitutional evidences were manifested.

The following spring (1884), the patient presented to me with gonorrhœa. The case proved obstinate, degenerated into gleet, and was under treatment first by injections, and afterwards by steel sounds all summer. July 20 he called my attention to two oval purplish blotches, each about the size of a watermelon seed, on the inside of the left leg. Careful inspection failed to discover any other cutaneous lesion or any enlargement of lymphatic glands. With doubt as to the nature of the eruption freely expressed, he was given one-fifth grain of protiodide of mercury pills—one three times daily for a month—when, the blotches having wholly disappeared, and no new one put forth, we discontinued the mercury, and we addressed ourselves to curing the gleet, at the same time watching for further manifestations of the syphilis (?). He was discharged in the fall, cured of his stricture. During 1885 he consulted me twice, February 25 and June 29, each time for a non-specific trouble. On inspection at these calls he showed no sign of syphilis. In the fall (1885), he consulted me as to the advisability of his getting married. Again I examined him with negative results, and on being further assured that it was nearly nine months since he had had illicit intercourse, I gave my sanction, and he was married in December to a beautiful and highly accomplished young woman.

Two months afterwards he came to my office with an abrasion on his foreskin. He stated that a few nights previously he had torn both himself and his wife while having intercourse. The sore he exhibited ap-

peared wholly benign, and on his assuring me that it was now some twelve months since he had gone astray, I gave him a little vaseline locally, and dismissed him. Four months afterwards he came to me exceedingly depressed, with the statement that his wife's physician had just told him that she had syphilis. On inquiry, I learned that the lesion on his penis had healed in a few days, but that shortly afterwards a "small lump appeared at its former site, that he again used the vaseline and the lump went away." Physical examination showed left mastoid gland and left epitrochlear very slightly enlarged, nothing else.

The history given of the wife's case was as follows:

About two months after the night of the accident, she discovered herself to be sore at the point of previous laceration, which had long since healed and been forgotten. Six weeks later a papular eruption appeared, and now, four months after infection, she is profoundly syphilitic, though improving rapidly on Otis' *pil. duplex*. Her case was placed under my care by her physician, its gravity being increased by the fact of her being four months pregnant. Examination of the vulva showed a very small *ostium vaginæ* with a discolored oval cicatrix at the base, external, of the right labium minus. The abrasion on the husband occurred on the left side of the foreskin, and to complete the history of the infection, I will state that the penis in the case is an unduly large one.

Both husband and wife have been known to me since childhood. He the embodiment of truthfulness, she of maidenly innocence and purity. Deceit, a false or imperfect history of the case are out of the question.

Here, then, is a case of syphilis latent for three years, and that latency not due to what Mr. Hutchinson is pleased to call the antidotal influence of mercury or to any treatment whatever. Here, also, is a case instructive from another standpoint, namely, that but for the accidental proof of direct maternal infection, it would go to swell the list of cases by which is supported the claim that in some occult but frequent way the act of impregnation becomes, or is, an act as well of syphilization.

LOUISVILLE, KY.

SYPHILIS OF THE PLACENTA.

1. THE existence of placental lesions in the course of syphilis is undeniable, but they are by no means constant.

2. In a certain number of cases, we may detect evidence of hypertrophy of the villosities with fibrous degeneration of the connective stroma and obliteration of the vessels, coincident with certain patches of fatty degeneration.

3. In cases where pregnancy does not come to full term, lesions of the placenta and its membranes may be found, more or less pronounced, accordingly as the delivery has taken place near the regular term.

4. Specific treatment may result in a foetus carried, born at full term and living, in women who have previously had successive abortions.—DR. ARTHUR GASCARD, *Th. de Paris*.

Correspondence.

TREATMENT OF PRURITUS AND RHUS POISONING.

LOUISVILLE, KY., July 21, 1886.

Editor of the Journal of Cutaneous and Venereal Diseases.

In reply to the request of Dr. Sherburne in the July number of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, that some of your readers should state their experience in the treatment of pruritus, I desire to say that I have had several patients, of late, suffering with this annoying complaint, and have in each case been able to give relief from the excessive itching by means of the following treatment:

A hot alkaline bath at night, containing four ounces each of carbonate of potash and carbonate of soda to thirty gallons of water, followed by inunctions of the glycerite of starch.

A lotion composed of: \mathcal{R} Acid. carbolicæ, \mathfrak{z} ss.; glycerinæ, \mathfrak{z} i.; aq., O.i., was sprayed upon the skin several times during the day, as recommended by Dr. Hardaway in the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, April, 1885. After the bottle of the atomizer has been filled with the lotion, five drops of the oil of peppermint is added. It is of especial importance to observe the method of treatment in these cases, rather than the drugs that may be used; the spray has the advantages over other methods of local application in being more cleanly, less troublesome, less irritating to the skin, and giving more speedy relief.

In the treatment of Rhus poisoning, I have obtained the best results from the use of a lotion composed of grindelia robusta, one drachm to four ounces water.

Respectfully yours,

J. CLARK MCGUIRE, M.D.

TREATMENT OF WINTER ITCH.

MT. PLEASANT, TEXAS, July 22, 1886.

To the Editor of the Journal of Cutaneous and Venereal Diseases.

In the July number of your JOURNAL OF CUTANEOUS AND VENEREAL DISEASES I notice a communication from A. B. Sherburne, concerning a skin affection which has puzzled him somewhat, and asks for some light upon the subject.

While the editor's comment upon it is to my mind satisfactory, I would like to add a few words as regards the therapeutics in said affection. The first acquaintance I made with this skin trouble was in February, 1884, a very cold and damp month. It seemed to take the form of an epidemic. In some instances whole families were troubled with it. It made its appearance in nearly every neighborhood in this section, and is still existing, though not to the same extent as when it made its first appearance; it is quite contagious.

My observation as regards its mode of attack is, that it makes its appearance in the majority of cases upon the arms, forearms, hands, and trunk respectively.

During 1884 I treated twenty-two cases. The first three cases I treated with remedies usually used in scabies, with negative results. I regarded the cutaneous affection up to the third case as due to a parasite. I then became satisfied, upon closer examination, that it was not of parasitic origin, but that it was due

to some climatic influence, and identical with winter itch, such as I had seen in the New England States several years ago.

The remaining nineteen cases I treated upon the assumption that I had no parasite to kill, and succeeded in each case in performing a cure in the course of one or two weeks, and since then I have had no reason to dissolve partnership with the treatment or my diagnosis. Several of my professional brethren still contend with me that it is of "bug origin." I have the patient wash the parts affected with water as hot as he can bear, using carbolic toilet soap or any good toilet soap. After drying, apply the following, by rubbing in well with the hands every night and morning: \mathcal{R} Potass. iod., \mathfrak{z} iv.; Iodi resub., grs. v.; Acid. carb. cryst., grs. xxx.; Aq., fl. \mathfrak{z} vi. M.

W. H. BLYTHE, M.D.

A PERSONAL CASE OF PSORIASIS—ILL EFFECTS OF ARSENIC.

To the Editor of the Journal of Cutaneous and Venereal Diseases.

DEAR SIR:—Thinking that the history of a case of psoriasis by one who has had it, and one who has made it something of a study, might be of interest, I send you this account.

About seven years ago, at the age of 14, an eruption appeared upon my head, in patches, resembling dandruff. I was treated by an apothecary, who gave me Fowler's solution. After taking this for some time, the eruption having mostly disappeared, I discontinued the use of the medicine, thinking the rest of the disease would disappear of its own accord. It did not, however, but came back as before. That the barber might not see the disease, I used to begin, about two weeks before I had my hair cut, to take the solution, which would make it partly disappear.

I was also treated by a physician, who gave me ointments; but they did me no good. Four years after its first appearance in my hair I had pneumonia; I was sent South, and within two months a few spots of psoriasis showed themselves on my body.

Nearly a year after this, the eruption having grown worse, I consulted an eminent specialist. He put me on acidum arsenicum in increasing doses, afterwards changing to sodii arsenitis, until I took three-eighths of a grain a day, and external treatment was also employed.

Soon after taking large doses of arsenic, the psoriasis spread rapidly over the body until but little healthy skin remained, some of the patches being three times the size of a silver dollar. The itching was so intense that I could not rest at night. My eyes became so inflamed that I could hardly use them, and my skin ghastly white. The arsenic was certainly producing an effect. At last the congestion of the skin became so great that I could not bathe in salt water and could not use soap, both giving great pain. Finding that I was growing worse, I concluded to try another plan of treatment. I stopped arsenic entirely, and upon advice took no meat, tea, coffee, tobacco, nor stimulants. I used laxatives, and applied externally a solution containing chrysophanic acid. I ate fish, fruit, and vegetables, and endeavored to improve my general health in every way I could.

I left for Europe, and upon my return, three months afterwards, the patches had not decreased in size, but the congestion was much less marked. I then took Rochelle salts before breakfast, and applied externally salicylic and pyrogalllic acids. There followed a slight improvement.

About six months ago I began to take Olei morrhue, \mathfrak{z} i.; Tr. nucis vomicæ, \mathfrak{m} i., after meals; sometimes a little calomel or Rochelle salts, and once in a

while a diuretic. I exercised a good deal, having until then been kept hard at study, took a cold bath before breakfast, besides doing everything else to improve my general health. I used an ointment of chrysarobin.

That was the turning-point in the disease. I began gradually to get better, until now I am perfectly well. I have read, with interest, the "Clinical Notes on Psoriasis," by Dr. Greenough, and the discussion, as reported in the "Transactions of the American Dermatological Association" at its ninth annual meeting. I perfectly agree with Dr. Hyde that itching may be the most distressing symptom of the disease. I was for months unable to get sufficient rest at night on that account, and the arsenic which I took seemed to aggravate the itching. When I applied anything irritating to the patches, that feeling would give place to the most intense burning.

I also believe, with Dr. Fox, that the location of the patches is of but little value as a diagnostic point; for, in the beginning, I had more patches on my chest and abdomen than on my back, and I have *never* had any *either on my knees or elbows*. And as to the remark of Dr. Fox that "too much stress is laid on the robust health of the patients," although they may seemingly be in the best of health, I am sure, if great care were taken, one might always find some weak point in their constitution.

I believe arsenic is bad where the disease is at all pronounced. It proved so in my case, congesting and drying the skin—the two things which should be expressly avoided. I think also that coffee, tea, meat, and stimulants are bad, for I noticed that, as soon as I stopped the use of these, the congestion of the skin began to decrease. Dr. Heitzman's views regarding the application of local remedies while the disease is acute seem to me good. I applied chrysophanic acid to my left forearm while the disease was yet acute, with the result of making the patches worse. And in regard to pressure or friction, some of the first patches on my body came from my clothes rubbing against me. The pruritus, which was so intense, dates from the time I began to take large doses of arsenic.

Dr. Hardaway ascribes two cases of psoriasis to the *inordinate* use of oatmeal. However that may be, I am sure that oatmeal in *moderate* quantity has done me good. I found that it was easy to digest, and that it acted slightly as a laxative. I can substantiate his views regarding the heredity of psoriasis, my grandfather having had it. Diet, and any aid one can give to digestion are of the utmost importance. I used to drink with my meals, and had a slight indigestion. Now I never drink until two hours afterward, and can digest anything. Although this point may seem of little account to some, I believe it is of the greatest importance. There is one thing to which, I am sure, physicians do not devote enough attention. Persons affected with skin disease are exceedingly sensitive, and their disease is so constantly in their minds that they sometimes become almost monomaniacs. This certainly aggravates the disease. If the physician will have them occupy their minds—and their bodies as well—a great change for the better will usually take place.

My experience with arsenic is perfectly in accord with the propositions which Dr. Fox presented to the N. Y. Derm. Society (see June number, C. AND V. JOURNAL). It increased the congestion of the skin, intensified the pruritus, caused the eruption to spread more rapidly, and was used to the exclusion of other internal remedies.

Regarding lanolin: I used an ointment containing chrysarobin and lard on one side of my body, and chrysarobin and lanolin on the other. My judgment is

in favor of lanolin, as it makes a very smooth ointment, and being more adhesive than lard it does not rub off so soon, and has, consequently, a longer time to be absorbed.

MEDICUS.

DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

Topical Applications in Diseases of the Skin.

AN interesting paper with this title, by Dr. H. G. Brooke, appears in the *Medical Chronicle*. After pointing out that a local treatment of skin diseases is gaining ground, the author admits that patients are often prejudiced against it, but says this lack of confidence is largely due to the imperfect way in which the local applications are made by the patients themselves. They are usually provided with a box of ointment, and then left to their own resources, with, frequently, insufficient directions. But if the patient have to undertake dressings on a large scale, there is a great deal of trouble involved, and a serious loss of time to the doctor if he have to undertake the task himself: and any form of treatment which involves much trouble or expense to the patient is pretty sure to be imperfectly carried out or neglected, with discredit to the doctor and dissatisfaction to the patient; hence an easy, inexpensive, and at the same time effective mode of application is a desideratum. For this purpose he praises the salve muslins and gutta-percha plasters of Dr. Unna, but finds that they have one or two drawbacks, the chief one being expense. He therefore devised another method, by having medicaments made up with a very stiff basis of wax, cocoa-butter, and oil, and cast into the form of a stick of cosmetic. This, when rubbed on the skin, is sufficiently soft to leave a complete coating of salve, and sufficiently hard not to run. On the body a piece of impermeable adhesive plaster may be placed over the anointed spots, the patch of plaster being sufficiently large to overlap the ointment by half an inch. Another basis which he found of great use consists of a mixture of equal parts of almond oil and thick gum-water. This makes a creamy emulsion, which, when well rubbed into the skin, soon dries and leaves an almost invisible coating. A fifteen to twenty-per-cent solution of salicylic acid in this oil-gum is recommended in cases of chronic eczema and lupus, and a ten-per-cent solution of pyrogallic acid proved very efficacious in psoriasis. No protective dressing is necessary. He then notices Pick's gelatin and glycerin base, as modified by Unna and Beiersdorf, the only drawback of which is its deficient adhesiveness. This he has endeavored to remedy by the addition of gum. Collodion, especially flexile collodion, is another useful base, as is also compound tincture of benzoin. This being thin and limpid, penetrates well and adheres firmly. Lastly he recommends that tar should be applied as an ethereal and alcoholic tincture: if this be painted on the skin it quickly dries, leaving only a brown stain with very slight odor. The tar tincture thus forms a smooth, protective, and almost waterproof covering, which may also be made to serve as a vehicle for other drugs, as salicylic acid, zinc oxide, etc.

The Removal of Superfluous Hairs by Electrolysis.

In this paper (*Birmingham Med. Review*) Mr. Gilbert Smith, after referring to the writings of Hardaway, White, and Piffard, proceeds to describe the apparatus needed, and the now well-known method of operating. Under a strong lens he finds that it is not difficult to introduce the needle directly into the follicle, but this is not absolutely necessary, as the requisite destruction occurs if the instru-

ment is in the immediate neighborhood. He recommends that not more than a dozen hairs should be removed at a sitting, owing to the papules and pustules which follow the operation, and says that minute scars are most apt to occur where it has been found necessary to introduce the needle into the same follicle a number of times, or where hairs situated close together are removed at one time; but even the most marked scars are scarcely noticeable after the first few weeks. He says that the operation is accompanied by pain which "is not unbearable," and that no return of hair has occurred in cases on which he has operated six months ago.

A Case of Recovery from Malignant Pustule.

Dr. W. E. Buck relates the following case (*Brit. Med. Journ.*): A veterinary surgeon, aged 31, felt a stinging sensation at the back of the right wrist; a small bleb formed, which he scratched off, and there was some tenderness of the elbow and armpit. He had a slight rigor. Two days later he was seen by a physician, who found the temperature 104°, and prescribed aconite and sodium salicylate. The rigors were repeated, and a black eschar began to form, which on the following day was about the size of a sixpence; its base was red and surrounded by a ring of vesicles. "Pure carbolic acid" was now injected under the eschar by an ordinary hypodermic syringe. Unfortunately, only a small quantity could be introduced, as it oozed out in the withdrawal of the syringe, and with it a serous fluid. Some of this was dried on a cover-glass and, after staining with methyl-violet, showed the well-known bacilli of anthrax. Large and frequent doses of sodium hyposulphite were now prescribed, and a large quantity of meat ordered. (An exclusive meat diet?) Under this treatment he rapidly improved. Three days later the injection of carbolic acid was repeated, and, as the patient felt well, the hyposulphite was diminished. The eschar did not finally separate for nearly six weeks, and the ulcer then soon healed. The disease was contracted exactly twelve days before its first appearance, by the examination of an animal which had died of anthrax. In connection with this subject we may notice the communication of Mr. Arthur Barker to the Royal Medico-Chirurgical Society, on November 24th last, "On the Distribution of *Bacillus Anthracis* in the Human Skin in Malignant Pustule." The part examined was excised on the tenth day after its first appearance, and the patient made a rapid and complete recovery. The bacilli occurred chiefly in the most superficial parts of the derma. Enormous colonies were found spreading over the surface of the papillæ, causing vesiculation of the epidermis; while in the deeper parts of the cutis, and in the bodies of the papillæ, only a few could be discovered; none at all could be found in the blood-vessels. It therefore appeared that the disease remained essentially local for a considerable time. Mr. Davies Colley did not think it was local for more than a day or two, after which bacilli anthracis were to be found in the sputa, urine, sweat, and fæces. Notwithstanding this wide distribution, the patient might recover.

The Leprosy Bacillus.

Dr. Lindsay Steven (*British Medical Journal*) has carefully examined a portion of affected skin excised during life, Gram's method being employed. Bacilli were present in enormous numbers, and were situated in rounded masses of granulation tissue, as well as in more diffuse infiltrations of round cells, but scarcely, if at all, in the more normal portions of the sections; none were met

with in the epidermis. The bacilli were contained within swollen lymphoid cells, and were also free, their general arrangement being often suggestive of their being contained within the lymphatic spaces. No bacilli were found in the blood-vessels. When examined by very high powers (1,600 diams.), they were seen to be fine rods, often sharply pointed at each extremity, and almost all of them contained small rounded spores, from three to five in number, giving a beaded appearance, and were certainly finer and smaller than tubercle bacilli.

The Treatment of Lupus.

Dr. Payne, in his valuable "Report of the Department for Diseases of the Skin in St. Thomas' Hospital" (*St. Thomas' Hospital Reports*, Vol. XIV.) gives an account of several cases which were treated by a local application of perchloride of mercury, as advocated by Dontrelepont. The mode of application was at first to keep the surface covered with a watery solution of corrosive sublimate applied on lint, and covered with oil-silk or gutta-percha. This being difficult to apply to out-patients, a sublimate solution mixed with glycerin was tried, to be applied several times a day; but the most satisfactory plan was to apply collodion containing the remedy in solution. The effect is that: (1) Points of suppuration appear in the lupus tissue, or a moist excoriated surface is produced; (2) this heals, and the lupus in that part is wholly or partially cicatrized, so far as the remedy has acted. In superficial patches, complete destruction of the lupus tissues is effected: in thick masses, the destruction is only partial. The process is sometimes painful, and sometimes not. The strength of solution employed was in the first instance gr. ss. ad $\frac{3}{4}$ i.; afterwards the strength was gradually increased up to gr. iv. ad $\frac{5}{8}$ i. Dr. Payne notes that this method of treatment, however useful, is by no means better than removal of the diseased tissue by scraping, which he still believes to be by far the best treatment in the first instance.

Cases of Syphilis Treated with the Tannate of Mercury.

Mr. Inglis Parsons (*Medical Times and Gazette*) gives an account of seventeen cases treated in the out-patient department in Guy's Hospital, the drug being given three times a day in pill an hour before meals, in doses of gr. iss. to gr. ij.; in one case gr. iij. No opium or tonics were ever given with it, nor were they ever required. It seemed possible to give it for any length of time without disturbance of the general health. As, however, all the cases ceased to attend after about four or five weeks, a longer attendance being quite exceptional, this point requires further observation. The cases came under treatment in periods varying from one week to twelve months from the onset of the disease, and the symptoms disappeared in most cases in from two to five weeks; one case showed only "slight improvement" after three weeks. In four cases there was slight soreness of the gums, and in three cases the bowels were a little loose, but severe stomatitis or diarrhoea did not occur in any case, and the patients usually said they felt better for the medicine.

JOHN CAVAFY.

LONDON.

Selections.

ICHTHYOL AND RESORCIN.

WHATEVER Unna writes, it behooves us to read, even though we may not always fully agree with him; he certainly is a most suggestive writer. His last contribution under the above title is a study of the effects of these comparatively new drugs in dermatological practice, which is valuable to us as a guide in their use, the practical experience of an observant clinician being always valuable. The first portion of the article is a restatement of his views upon cornification ("Ueberhautung und Ueberhornung"), the action of ichthyol and resorcin being upon the same principle as that of pyrogallol, chrysarobin, etc., that is, they are reducing agents, drawing oxygen from the tissues. These agents act differently, according to the strength of the preparation, and as to whether they are used upon the sound skin, the denuded skin, or upon skin affected by parasites. The action of weak strengths shows itself in alteration of the corneous layer of the skin; it becomes thicker, denser, and more solid, and many rows of uncornified prickle cells are added to the normal corneous layer, which are probably made up for by new formation of the lowest prickle-cell layers. When the weak action is long continued, there results a division of the corneous layer into two parts, an upper, more or less dark, dead part, and a lower, light-colored part. Another effect of weak strengths of these agents is pustulation, on account of an abnormal closure of the mouths of the follicles by the hypertrophied corneous layer and consequent perifolliculitis.

If the action of the reducing agent goes deep, we have a permanent narrowing of the blood-vessels, and the skin becomes cooler, less swollen and painful, and paler.

All reducing agents discolor the corneous layer of the skin. Resorcin colors it dirty yellow when ointments are used, reddish-brown when in form of plasters. Ichthyol produces a yellowish-brown, like what is seen in sunburn. This discoloration is always more marked in the presence of an alkali. By long-continued use of the agent, the tendency to discoloration is lessened.

The action of high strengths of these agents is the same as that of low strengths, as far as the corneous layer is concerned, only more rapid. But new effects are produced elsewhere. The prickle-cell layer decays and softens, and bullæ appear; the walls of the papillary blood-vessels are damaged; exudation and, finally, emigration of pus-corpuscles takes place; the corneous layer is more and more deeply undermined, and at last thrown off as a continuous membrane. With resorcin and ichthyol, this process requires days or weeks. The subsequent cornification takes place more rapidly and strongly than under any other class of agents, and the cicatrix is therefore smoother and more even. If pustules are present, their covers are thrown off, and not reformed; hence, in acne, furuncles, etc., high strengths should always be used. Upon cicatrices of small-pox and acne, and upon the indurated skin of eczema, scleroderma, and elephantiasis, high strengths exert a softening influence. The first effect of these high strengths is to cause slight pain, which later may become quite severe, especially when pustulation or degeneration of tissues takes place.

Pure ichthyol, or strong applications of resorcin, used upon a simple lesion of continuity, such as an incised wound, will cause an instantaneous shrinkage, and a healing without scar. They have a good effect upon burns, so long as the bullæ are small and intact. Applied to raw surfaces they produce a high grade of catarrhal inflammation, œdema, and pain. On the other hand, when injected into the subcutaneous tissues, into suppurating glands, fistulæ, and the like, they produce a primary rapid union without inflammation. It may be given as a general rule, that the poorer a tissue is in blood-vessels and nerves, and the drier it is, the better will it bear strong doses of these agents. Applied to lesions of the skin in proper dosage, there follows a reduction of the productive elements of the skin and a preponderance of the supporting elements, and hence a tendency to cornification and healing. *Ichthyol*, of which Unna always uses the ammoniasulphate (sulfoichthylsaur ammonium), is of great use in *Rosacea*, of which disease he recognizes two forms, one approaching to a usual erythema and eczema, with bright-red color, smooth or easily scaly skin, without comedones or acne; the other consisting of a papular acne upon bluish-red, swollen base. In the first form a low strength of ichthyol is to be used, in the form of ointment or paste; or washing with ichthyol soap and hot water, and the internal administration of the drug. In the second form the drug is to be used liberally, both internally and externally. Under its use in either form a rapid paling of the surface takes place, a thinning of the epidermis and disappearance of lesions.

It is useful in *acne*, whether pustular, papular, or indurated, employed both inwardly and outwardly, and in full doses.

The author recognizes two chief groups of *eczema* in which ichthyol does good one depending upon nerve action, and the other upon parasites. "Nervous eczema" affects chiefly adults, appears in a multiple manner, with an inclination to symmetry. Its lesion is a vesicle, which is full and does not break down so readily as in other forms. These vesicles come out in groups like zoster, and are to be differentiated from it by want of inflammatory areola and pain, and by their slower course and intense itching. The groups follow nerve courses, and tend specially to affect the extremities. This form is prone to relapse, and is brilliantly amenable to ichthyol administered internally and externally. At first it may be painted on in almost full strength on the extremities; in ten-per-cent watery solution on the face. As soon as the skin becomes dry under its use, it is to be stopped and not used again until a fresh eruption appears. The internal use is to be continued. To this same form of eczema belong those cases occurring with periodic attacks of asthma. Here ichthyol given by the mouth acts favorably upon both the asthma and the eczema. Children can take five to ten drops daily, in wine or beer, and if a relapse takes place the dose is to be increased four or five times for a few days.

The chief parasitic form of eczema is that occurring in strumous children, affecting the openings of the body (nose, mouth, etc.), and complicated with other signs of scrofula. It is not very itchy, but is erythematous, moist, tends to crust, and causes a great deal of œdema. Here ichthyol is a reliable drug, given by the mouth, in daily doses of five drops, and used externally in say five-per-cent strength, according to the condition of the skin. Another form of parasitic eczema is that which attacks opposed surfaces—the intertrigo form. Here ichthyol is to be applied in ten-per-cent ointment, and one rubbing will often cure a fresh case.

Upon other parasitic troubles, as Unna regards them—*pityriasis capitis*, *sebor-*

rhœa sicca capitis, eczema seborrhœicum, furunculosis, erysipelas, and erysipeloid—the drug exerts a no less wonderful influence, when used in ten to fifty per cent ointment. In the treatment of *psoriasis, sycosis, and lupus*, ichthyol is but an adjuvant, though a useful one. It is useful after the treatment of *lupus* to bleach the skin and smoothe the scar.

Lichen urticatus is very promptly cured by the internal use of ichthyol. *Urticaria, erythema multiforme et nodosum, herpes progenitalis et labialis, zoster, and dermatitis herpetiformis* are all favorably influenced by ichthyol in high percentage externally, while the chronic cases get well rapidly under internal administration of the drug.

Applied in full strength to flat *condylomata*, ichthyol removes them without a scar; but its use must be continued for some little time after their disappearance to insure against a return. *Keloid*, especially of the cicatricial kind, occurring on the face, can be removed by repeated applications of a strong ointment or colloid solution.

Ichthyol, then, is a very useful drug in conditions in which we have an abnormally soft thin cuticle, as in subcutaneous swelling and inflammations with sound surface (furuncles), in cedemas, angiectases, inflammations and new formations of the skin without implication of the cutis (urticaria, rosacea, etc.), in inflammatory processes of the skin with hyperkeratosis (acne), or at least without loss of resistance of the cuticle (herpes, etc.), and in parakeratoses (psoriasis, pityriasis, etc.). In all these the drug can be used in full strength. The amount of the drug to be given by the mouth is regulated more by the individual than by the dermatosis. The minimal dose is, for children: about two drops; for larger children and adults, five drops a day. For most people the dose can be raised to five or ten drops of the ammonia-sulphate three times a day. When the full dose is reached, it should be continued for some time.

The internal administration is of special use in chronic, obstinate, relapsing skin diseases.

Resorcin has not so wide a field as ichthyol. It is useful in *pityriasis capitis, alopecia pityrodes, squamous eczema* of the head, and seborrhœal eczema, in the form of a 5 to 10% ointment, according to the amount of inflammation present. Sometimes it is necessary to use a 20 to 30% ointment to overcome a stubborn remainder from the disease. In *psoriasis* it acts well in 10 to 20% ointment. It is useful in several forms of parasitic (?) *eczema*, as where it occurs in the form of dry itchy patches upon the face, or in the form of small, round, sharply circumscribed, scaly patches resembling pityriasis versicolor, or in the form which occurs about the openings of the body; also in a form which resembles psoriasis, differing from it only in that the fine scales lie centrally on the papule, leaving its red border free; the scales never reach the magnitude nor attain the silvery look of those of psoriasis; the papules often have a depression in the centre, and are very itchy; it is further distributed over the body and does not specially affect the elbows and knees. Also in the form of *eczema flavum, lichen circumscriptus, or eczéma acnéique*. In all these resorcin renders good service, especially if they are located on the face. It is well to begin with a 2% ointment or paste and gradually increase its strength with the progressive healing.

It is of great service in *ichthyosis, in trichophytosis barbe*, and in *cicatricial keloid*. Further good results are had from it in *erysipelas* and *epithelioma*.—*Monatsschrift. f. prakt. Dermatol.*, May, 1886.

THE MICROBE OF SYPHILIS.

THE following account of some of the most recent investigations in this subject is abstracted from the *Wiener Medizinische Wochenschrift*, No. 14, 1886. At a recent meeting of the Berlin Society for Internal Medicine, Klemperer reported that he had treated preputial smegma, taken from nine healthy individuals, according to Lustgarten's method. He found in every specimen the smegma-bacilli described by Alvarez and Favel. These, like the syphilis bacilli, differ so greatly in length, thickness, and form that there is some doubt whether they belong to the same species. They resembled the syphilitic bacilli in appearance and in reactions, but were more readily decolorized by acids and alcohol than were the latter. The speaker had found Lustgarten's bacilli in the secretion of broad condylomata, but had never found them in sections of condylomata, indurated patches, or gummy tumors. Köbner said he had found the presence of the bacilli in the secretions, and especially in sections, of syphilitic lesions to be very inconstant. He doubted the identity of Lustgarten's bacilli with the syphilitic virus. Finger had shown that the micro-organisms were present in the secretions in all three stages of syphilis. Were, then, these bacilli the bearers of the specific virus, he did not understand why the disease could be transmitted by the secretions in the first and second stage, but never by those of the third.

In an article on the "Contagium of Syphilis," in the *Deutsche Medicinische Wochenschrift*, Disse and Faguchi state that they have found spores in the blood and short bacilli in the indurated patches and papules of syphilitic patients. They also obtained from the blood of syphilitics pure cultures in gelatin and meat-broth of a bacillus, which caused syphilis in dogs, sheep, rabbits, and white mice when inoculated. An induration occurred at the point of inoculation, and was followed some months later by gummy tumors in the internal organs. From the blood of these animals could be cultivated the same bacillus as from the blood of syphilitics.

Matterstock has recounted in a pamphlet the results of his studies in the clinic of the University of Würzburg. He found the bacilli corresponding to Lustgarten's description, in sections made from sclerosed patches, papules, broad condylomata of the genitals and anus, and gummy tumors of the skin. These lay, from one to four together, in cells two or three times the size of white blood-corpuscles; and in rare instances a few solitary rods were found lying free between two cells. The bacilli were found in great numbers in the secretion of papules, which, from their protected situation, covered with long-standing secretion, and kept at a constant temperature, resembled miniature culture-ovens. Experiments upon the smegma-bacilli had led to the same results as those obtained by Alvarez and Favel. He had found no reliable means of distinguishing between these and Lustgarten's bacilli by staining methods. His conclusions were that not only was the etiological significance of Lustgarten's bacilli not demonstrated, but even their diagnostic value was nil, since they could not be distinguished by their reaction to coloring agents from other bacilli.

POLYMORPHOUS ERYTHEMA: ITS NATURE AND ITS SPECIFIC TREATMENT.

M. VILLEMIN, in a communication to the Academie de Médecine upon "Polymorphous Erythema; its Nature and its Specific Treatment," discusses the question whether this affection is allied to rheumatism or is assimilated in its general

characters to the infectious diseases. He says: If therapeutic specificity implies etiological specificity, if the same remedial agent causes the various eruptions comprised under the term polymorphous erythema to promptly disappear, and the same time dissipates the other general symptoms, such as fever, rheumatism, pain, and other disorders of the nervous system, we shall have the right, it seems to me, to consider these moot points as to its nature settled, and to affirm that:

1. The erythemas to which dermatologists have given the names of nodose, papular, circinate, vesicular, etc., and which are embraced under the common name of polymorphous erythema, are only varieties of the same morbid type.

In the evening your patient may have a high temperature, a bright-red, indurated, painful erythema, a distressing lumbago, severe pains in the limbs and in the joints, prostration, insomnia, etc. The next morning all is changed; the temperature is normal, the erythema has paled, lost its induration, and is disappearing; the pains have vanished, the articular swellings are dissipated, and in three or four days not the slightest trace of the disease remains.

The higher the fever the more marked its fall. In twelve hours we sometimes see the temperature diminish three degrees. The pains are allayed almost as promptly as the fever, but when swellings and œdemas are present, time is, of course, necessary for the absorption of the extravasated fluids.

In addition, the use of the iodide of potassium has always sufficed to abort the tendency to relapses which are so frequent in this affection.

Auto-inoculation of the contents of the vesicle has been tried, but thus far with negative results. Villemin's conclusions are based upon his observations in twelve cases treated by him.

2. That polymorphous erythema is a general disease of a specific nature, of which the cutaneous eruption is only a syndrome.

3. That the pains in the fibrous tissues and the articular swellings are not related to rheumatism, but are manifestations of the disease and are produced as the cutaneous eruption itself is, by a unique morbid cause. The remedial agent to which allusion has been made is the iodide of potassium. The *materia medica* possesses no other agent so marvellously specific as is this salt in polymorphous erythema.

In from twenty-four to forty-eight hours, and with an average dose of thirty grains per day, all symptoms of the affections are simultaneously modified in the most surprising manner. Quinine has certainly not in intermittent fever such rapidity and such certainty of action.—*Bulletin de l'Académie de Médecine*, No. 20, 1886.

CONTRIBUTION TO THE STUDY OF SYPHILIS OF THE INFERIOR MAXILLA.

THE inferior maxilla is not, as certain authorities have contended, secure from the attacks of syphilis. Specific disease of the inferior maxilla may present itself under diverse forms, giving rise to difficulties of diagnosis and to therapeutic indications which vary in different cases.

Specific lesions of the inferior maxilla may result from either hereditary or acquired syphilis, and present themselves under three different forms, 1st, under the form of periostitis or gummosis osteo-periostitis; 2d, under the form of exostoses or hyperostoses; 3d and finally, under the form of progressive rarefactions and disappearance of the dental alveolar arches.

Gummosus periostitis may be accompanied with ulcerations of the same nature, either of the skin or mucous membranes; it may be partial or diffuse; it may develop at a relatively early period of syphilis; its terminations are variable, depending upon whether the patient receives specific treatment or not. Where specific treatment is instituted in time, complete resolution may take place without leaving a trace, or there may remain exostoses or hyperostoses, resulting in a more or less marked deformity of the maxilla. If the affection is abandoned to itself, the most frequent termination is necrosis, more or less extensive, of the inferior maxilla, and, in this latter case, may require a surgical operation involving a partial or total resection of the lower jaw. Sometimes there result spontaneous fractures of the maxilla.

The diagnosis of gummosus periostitis of the maxilla, especially if accompanied with ulceration, may be extremely difficult: it should be differentiated from simple alveolo-dental periostitis, from phosphorus necrosis, from osteo-sarcoma, and also from tuberculosis when the ulceration occurs on the mucous surfaces.

Exostoses and hyperostoses of the inferior maxilla may occur as a result of gummosus periostitis (Otto Weber). They occasion no inconvenience aside from their presence and the deformity of the bone upon which they are situated. They may compress the inferior dental nerve. Antisyphilitic treatment dissipates them in a certain proportion of cases.

The progressive resorption of the alveolo-dental arches is characterized by the loss of the teeth, and the total disappearance of the dental arches. This spontaneous loss of non-carious teeth is sometimes accompanied by severe hemorrhage. The duration of the affection is quite protracted.

The treatment of syphilis of the inferior maxilla does not differ from that usually employed in osseous syphilis in general.—DR. F. CHABAUD, *Thèse de Paris*.

SYMMETRICAL GANGRENE AND LOCAL ASPHYXIA.

DR. O. KOERNER, of Frankfort, reviews, in the *Centralblatt für klinische Medizin* of May 29, an article by Dr. Hochenegg which appeared in Heft 4 of the *Med. Jahrbücher* for 1885, on symmetrical gangrene and local asphyxia. Symmetrical gangrene is a form of spontaneous gangrene, caused by nervous disturbances of a trophic or vaso-motor nature, or by an unknown vicious blood mixture. It is not an independent disease, but a symptom that may represent the most different maladies. Only a small proportion of the cases are followed by simple gangrene, the majority being found in combination with the symptoms of another fundamental disease which stands in etiological relation to it. Such diseases are disturbances of nutrition, as those which appear after severe physical exertion, especially if continued during a number of days without stopping. Further, those cases that appear in chlorotic and chronically anæmic individuals, and especially with children. Also the sequelæ of acute infectious diseases belong to this category.

Hysteria is given as an example, the symptoms of which symmetrical gangrene may accompany, and it is further maintained that symmetrical gangrene and local asphyxia may constitute a symptom of neuritis. Dejerine and Leloir, Monnstein, Pitres, and Vaillard are quoted as authorities for this. It seldom occurs with acute, but most frequently with chronic, very slowly progressing neuritis. It is often limited to peripheral localities, for instance, the extremities, the main trunk of the nerve remaining intact. It may also be derived from brain.

disorders or diseases of the spinal cord without the appearance of peripheral neuritis. Syringomyelia is given as an instance among others of this nature. When accompanying diseases of the central nervous system, Hochenegg regards symmetrical gangrene as analogous to Charcot's acute decubitus, but does not view it as being of so ominous a nature.

Aside from the treatment of the causal disease, the application of dry heat, in the form of dressing with cotton, and extending considerably beyond the diseased parts, is recommended as the best method. The changing of the bandages must take place in a warm room. Electricity and irritating salves are dangerous in the extreme. If acute gangrene in symmetrical form sets in, it is to be treated surgically, the same as ordinary gangrene. Hochenegg observed five cases among seven thousand hospital patients.

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De la Methode à suivre dans le Traitement du Lupus Erythémateux et de certaines autres Dermatoses, par le DR. BROCCQ, Médecin des Hôpitaux. Reprint *Journal de Méd. de Paris*, June, 1882.

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Il Ferrato di Mercurio—Nuova Medicamento per la Cura della Sifilide, pel PROF. CAV. PIETRO GAMBERINI.

Casuistisches zum Lichen Ruber Planus der Haut und Schleimhaut, von DR. K. TOUTON, in Wiesbaden. Reprint *Berliner Klin. Wochenschr.*, 1886.

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Original Communications.

TROPHONEUROSIS OF THE SKIN CAUSED BY INJURY TO THE
MEDIAN NERVE.¹

BY

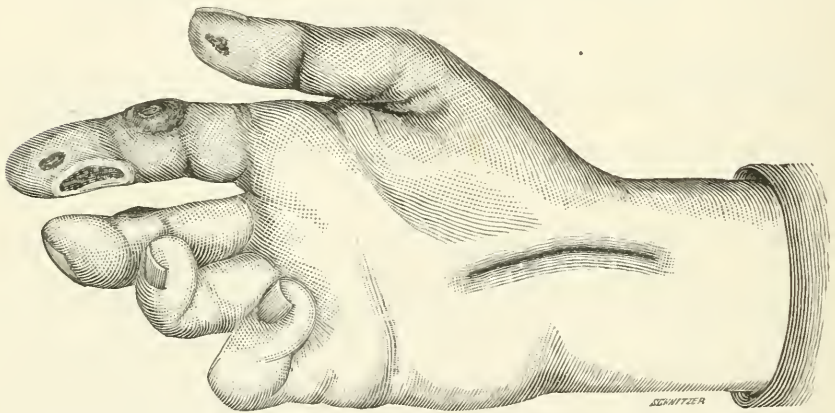
G. H. TILDEN, M.D.

E. F., 55 years of age, a carpenter by trade, was wounded in the wrist by a circular saw on November 10, that is, exactly four months before coming under observation. The linear cicatrix resulting from this wound is about two and one-quarter inches in length, and its direction parallel to the long axis of the arm. It is situated on the flexor surface of the right wrist at about the middle line, and being slightly curved, its convexity is directed toward the ball of the thumb. The wound was sewed up immediately after the accident, and union took place in about ten days, at the end of which time the stitches were removed. Three or four days after the infliction of the injury, the patient began to be conscious of a loss of tactile sense and feeling of numbness in the last two phalanges of the fore and middle fingers, which disturbance of sensation has continued and steadily increased in severity ever since. There was also evident, at first, a similar feeling of numbness in the thumb, but to a less degree, which has been gradually diminishing, and is now no longer experienced.

About three weeks after the accident, there appeared for the first time a bulla, situated upon the terminal phalanx of the index finger, and since then similar lesions have developed from time to time upon the last two

¹ Read at the 10th annual meeting of the American Dermatological Association.

phalanges of the fore and middle fingers. These bullæ are about the size of a pea, their epidermal covering is tense, and they are filled with a clear serous fluid. They make their appearance every two or three weeks, are unaccompanied by any subjective sensation, being rapidly developed generally during the night, and do not increase in size after having once been formed. The region of the skin upon which they are situated is reddened to a slight degree before they make their appearance. Removal of their epidermal covering discloses a superficial excoriation which heals in a week or ten days. When several of these lesions have been developed successively in the same spot, there is finally produced a condition of thickening and accumulation of epidermis, a true tylosis, such as is shown on this side of the forefinger in the portrait, and it has been the custom of the patient to pare down these accumulations of epidermis with a razor. About two weeks before I first saw him, the largest



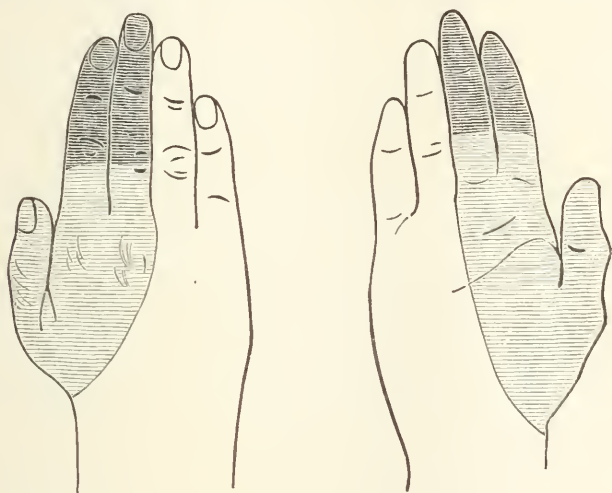
bullæ which had yet appeared was developed, giving rise to the ulcer situated on the inner side of the tip of the forefinger.

The skin in general over the last two phalanges of the affected fingers, more particularly on their dorsal surfaces, is tense, of a white color and glossy texture, while these fingers upon palpation offer a sense of solidity, of greater resistance, and less elasticity of tissue than is furnished by the other fingers. The growth of the nails is unaffected. The region of the cicatrix in the wrist is somewhat sensitive to pressure, and there is entire loss of sensation in the last two phalanges of the fore and middle fingers. Dr. W. N. Bullard kindly examined the patient for me with reference to a more exact determination of the condition of the hand as regards loss of sensation, motive power, and reaction to electric stimulus.

In the portion of the hand designated by light shading there was partial anæsthesia, the patient being able to distinguish between the point

and head of a pin. In the last two phalanges of the fore and middle fingers, the region indicated by dark shading, there was total anæsthesia and analgesia, inability to make distinction between two points and one, and absence of the temperature sense. Tested by the dynamometer, the right hand was capable of exerting but one-half the force of the left. The reaction of all the muscles in the anæsthetic region was diminished to the faradic current, while the galvanic current excited the so-called degeneration reaction in the first and second interossei muscles.

Six weeks' treatment, in the shape of the application of the faradic current to the hand and forearm, caused decided improvement in all the symptoms, both subjective and objective. The power of motion and muscular force increased, the sensation of numbness in the fingers became



much less marked, while the tenderness upon pressure over the cicatrix in the wrist disappeared entirely. But one bulla was developed during the time of treatment, and the ulcer on the forefinger nearly healed.

The patient then gave up treatment and resumed work, using his right hand to manipulate a hammer. No particular change in the improved condition of the hand was noticed until the end of about three weeks, when quite suddenly all the subjective symptoms reappeared, the fingers became stiff and their power diminished, the feeling of numbness in them returned, while the sensitiveness to pressure upon the cicatrix in the wrist became again manifest. I saw him at this time, and a freshly formed bulla had developed upon the back of the second phalanx of the middle finger. The ulcer which had formerly existed on the inner side of the forefinger was transformed into a crater-like callus, the

thickened epidermis being arranged in concentric rings around the centre, which presented a small blood crust covering an excoriation. The whole skin of the end of the forefingers was extremely thickened and indurated, doubtless on account of the friction caused by the use of the hammer, these changes in the epidermis being apparently much greater than could have been occasioned by the same amount of friction applied to normally innervated skin. The hand was in fully as useless a condition as when he was first seen, all that had been gained by treatment having been lost.

It was proposed to the patient that an incision be made in the region of the cicatrix, with the intention of finding out the exact condition of things, and if possible to remedy them. This was the last time I saw him, although he promised to return after having made up his mind as to the operation.

The evidence that there are nerves which control in some way the nutrition, the growth and repair of tissue, is a matter of inductive reasoning rather than of anatomical demonstration. Whether these nerves exist as individual and special nerve fibres, or whether the motor and sensory nerves are the ones by which the nutrition of tissues is governed, is unknown. The latter seems to me to be the more rational view, namely, that the so-called trophic influence is transmitted from the nerve centres and ganglia to the tissues by the motor and sensory nerve fibres, and that interference with the conducting power of these nerves, by disease or injury affecting them at some part of their course, as well as disease of the ganglion and central nervous system, may disturb, not only motor power and sensation, but also the nutrition of tissues. That it always does so is by no means the case, but why trophic changes should take place in one instance and not in another is not clear.

Leaving out of consideration instances of trophic changes in the skin due to disease of the nervous system, the most notable examples of which are furnished by zoster, perforating ulcer of the foot, some forms of leprosy, and so-called symmetrical gangrene, cases of similar changes in the skin caused by injury to the nerves are not uncommon, a number of instances being given by Mitchell and by Leloir.

Such changes are more apt to follow partial injury to a nerve than complete section thereof, and there very commonly exists in these cases a condition of chronic irritation of the injured nerve fibres, occasioned by pressure, constriction, or inflammatory processes. A noteworthy example of this is furnished in a case reported by Paget, in which the median nerve was compressed by a large callus, resulting from fracture of the lower end of the radius. "The thumb and first and second fingers ulcerated; and the ulcers resisted all treatment until the wrist was kept bent in such a way as to relieve the nerve from pressure. The ulcers re-

turned whenever the hand was allowed to resume its former position."

The changes in the skin commonly seen in these cases are the condition of so-called glossy skin and vesicular and bullous eruptions, followed by superficial ulcerations, which, as a rule, readily heal. Tyloitic changes may occur as in the present instance. The treatment in these cases consists in the application of electricity to the injured nerve, and of blisters over the seat of injury. A last resource is to cut down upon the affected nerve, and endeavor to relieve by surgical means any constriction of or pressure upon the nerve which may be found to exist. If no such condition of things can be detected, resection of a portion of the nerve might be advisable, since complete section of a nerve is not likely to be followed by spontaneous trophic changes, and since, according to Leloir, it has been found by Brown-Séquard and Verneuil that resection of portion of the affected nerve is sometimes followed by the arrest of trophic changes.

NOTES ON DRUGS.¹

BY

HENRY G. PIFFARD, M.D.

UNGT. *Hydrargyri Ammoniati*.—Until within about three years, the white precipitate ointment has been with me a favorite application in moist eczema, and during a period of about eighteen years I can recall but two or three accidents with it. Since then, however, that is, during the last three years, its use has so frequently been followed by symptoms of irritation that I had well-nigh abandoned it. A comparison of the officinal preparation now furnished, with that formerly in use, explains, I think, the observed differences in their effects. The present ointment is made with pure lard, while formerly it was made with lard and wax. The pure lard tends to promote the absorption of the mercurial, and thus explains, I think, its irritating effects. The present ointment is too soft, and mechanically is not as good as the older preparation. For some months I have been using an ointment made with *ceratum cetacei* instead of the officinal preparation, with satisfactory results.

Acidum Sulphurosum.—The present officinal preparation is only about half the strength of that prepared according to the late pharmacopœia. Squibb, however, retains the latter preparation, and care should be exercised in prescribing, lest one preparation should be inadvertently substituted for the other.

¹ Read at meeting of American Dermatological Association, Aug. 26, 1886.

Traumaticin.—Under this name, several manufacturing firms offer a ten-per-cent solution of gutta-percha in chloroform, equivalent to the *Liq. Gutta-perchæ* of the pharmacopœia. The preparation is clear and closely resembles collodion in appearance. Beside its usual employment as a vehicle for chrysarobin, I have found it useful in the application of sulphur, bismuth, white precipitate, oxide of zinc, and other substances. The addition of a slight quantity of carmine renders the mixtures less noticeable when applied to the skin. Squibb's *liq. gutta-perchæ*, however, is dark in color, and, from an æsthetic standpoint, is not a desirable preparation.

Lanolin, or oil from wool, comes to us from abroad in the form of a soft, foul-smelling ointment. In this country it is protected by letters-patent No. 271,192. In the specifications, this new product is claimed to be a "perfectly white, neutral, colorless ointment," which description certainly does not apply to the article as supplied for sale.

The chief claims made in behalf of lanolin are, that it is more readily absorbed than any other fat, and that it promotes the absorption of medicinal substances combined with it. Since in the majority of cases we do not wish absorption, but surface action only, this property is a detriment, and lanolin is to be condemned as a general basis for ointments. An exception to this may be a combination of lanolin and tar, which, in suitable cases, appears to work better than the officinal tar ointment.

Ichthjol appears to me to closely resemble the old *oleum sulphuratum* or balsam of sulphur, and would doubtless obtain a recognized place in therapeutics, were it not that it has been, in this country at least, brought prominently forward as a general cure-all for cutaneous diseases, and advertised as such in the public journals, theatre programmes, railway stations, etc. This places it in the same rank as Cuticura and similar proprietary compounds, and removes it from the armamentarium of the scientific physician.

A STUDY OF SIMPLE PAPILLOMATA.

1. SIMPLE papillomata or papillary hypertrophies may develop upon the external surface as the result of prolonged irritations.

2. They have as seats of predilection the backs of the hands, the fingers, especially in the neighborhood of the articulations.

3. These papillary hypertrophies possess in themselves no gravity, but they occasion from their localization and continual increase pain and difficulty of movement.

4. The patient may be compelled to suspend his occupation; therapeutic intervention is therefore indispensable. The only rational treatment is destruction of the papillomata, which may be effected by the curette or by cauterization.

—DR. EDWARD NATIN, *Th. de Paris*.

SCARLATINA AND SCARLATINIFORM ERUPTIONS FOLLOWING
INJURIES AND OPERATIONS.¹

BY

I. E. ATKINSON, M.D.,

Professor of Materia Medica and Therapeutics, and Clinical Medicine and Clinical Professor of Dermatology in the University of Maryland.

ALTHOUGH reports of scarlatina and scarlatinoid eruptions following injuries and surgical operations were to be found in medical literature, general attention was more especially attracted to them by Sir James Paget in 1864 in a clinical lecture. In his "Clinical Lectures and Essays" (1875) he devotes a chapter to the subject. He says: "There is something in the consequences of surgical operations which makes the patients peculiarly susceptible to the influence of the scarlet fever poison." In France, Trélat² was the first to accept the views of Paget concerning the nature of these rashes, though they had already been observed by Civiale, Germain Sée, Tremblay, and others. Rashes more or less resembling scarlatina were reported by Jonathan Hutchinson, Hilton, Bryant, Lea, Moore, and others, and in St. George's Hospital Reports for 1879 is a notable article by Stirling, in which the subject is considered. Scarlatinoid rashes in surgical cases had generally been considered to be of septicæmic origin. In Guy's Hospital Reports for 1879 appeared two papers supporting the proposition that an especial liability to scarlatina is shown by those who have recently sustained injuries or undergone surgical operations. The first of these, "A Contribution to the Etiology in Scarlatina in Surgical Cases," by W. E. Paley, was communicated by Goodhart with observations. It was based upon records of Evelina Hospital for Sick Children, and contained the reports of twenty-five cases. Of these patients, nineteen were shown to have been exposed to scarlatina, and of the remaining six, all save one had possible sources of infection. Goodhart, however, was careful not to assert that all such red rashes should be attributed to scarlatina. The scarlatinous nature of the cases reported in the paper will be everywhere admitted. The second paper was by House, and is based upon four cases of surgical scarlatina, occurring epidemically in Guy's Hospital. The epidemic ceased upon the establishment of isolation, and its scarlatinal nature cannot be doubted. While this author does not venture to affirm that there is *not* "such a thing as a rose rash in a typical case of septicæmia," he

¹ Read before the American Dermatological Association at Greenwich, August 26, 1886.

² *Le Progrès Médical*, Sept. 14, 1873.

believes "that the more these cases are studied, especially when the disease occurs in groups of cases and in patients that have been dressed antiseptically, the deeper will become the conviction that they have little in common with true septicæmia, and that they all originate in the first place in a true scarlatinal infection." Riedinger,¹ who reported ten cases of scarlatina after wounds and operations, reached his diagnosis from symptoms, and was only in one case able to trace a contagious influence. He also concluded that there exists in wounded persons a predisposition to scarlatina. At the International Medical Congress of 1881, in London, Mr. Howard Marsh and Riedinger re-affirmed this opinion, and, in the succeeding discussion, Holmes and Goodhart coincided with their views; the former, however, declared that many cases of "surgical scarlet fever" are due really to pyæmia and other causes.² It appears, therefore, that most recent writers decidedly incline to the opinion that these eruptions are generally dependent upon true scarlatina. When any tendency toward epidemic prevalence is shown, every one will agree with such conclusions—as much cannot be said of these rashes when occurring in isolated cases. Broadly speaking, all debilitating causes predispose those influenced by them to attacks of infectious disease. Is this more especially true of scarlatina?³ A glance at Paley and Goodhart's figures is instructive. Of twenty-five cases observed, scarlatina attacked seventeen after operation; seven of them were without any wound whatever, and one had an old sinus only. Many of the cases of other writers had no external wound whatever. Unfortunately, reporters most rarely note whether their patients had ever previously had scarlatina. Most children, when first exposed to the contagion of this disease, become infected; is it remarkable that they are unable to withstand it when it attacks them weakened by injury or surgical operation? Trent, indeed, reasoning from imperfectly considered and insufficient data, has concluded that scarlatina is less apt to attack surgical cases than others.⁴

But, apart from epidemic influences, it is probable that scarlatiniform eruptions in the wounded may justly, in a large proportion of cases, occur quite independently of scarlatina. Rashes of septicæmic origin are well known to occur. Various fugitive eruptions often develop under nervous irritation of indifferent origin, as when they proceed from certain topical influences, or from various ingesta, whether as food or medicines, or, finally, from strong emotional disturbance. Urticaria and erythema not rarely follow surgical operations. Spencer Wells has seen a rash like that of scarlatina cover a woman's body in less than a quarter of an hour

¹ *Centralbl. f. Chirurg.*, No. 9, vii., 1880, 134.

² See *Transactions*, vol. iv., p. 177.

³ Paley's figures show a like predisposition to measles under similar conditions.

⁴ *Centralbl. f. Chirurg.*, No. 18, vii., 1880, 291.

after the application of perchloride of iron to a cauliflower excrescence of the uterus. One patient always developed urticaria upon the introduction of the speculum.¹ Such idiosyncrasies are not uncommon.

The rashes of septicæmia are, it is true, usually urticarial in character, but often enough are erythematous, when they appear as large plaques, mingled or not with urticarial wheals, scattered irregularly over the body and of uncertain duration. It must be admitted that true scarlatiniform septicæmic rashes are not common.² But there seems to be excellent evidence that they do occur. How, otherwise than upon a theory of sepsis, using the term in a broad sense, are we to account for cases such as the following: Konetschke³ treated a boy nine years old for compound fracture of both bones of the leg. The wound was dressed antiseptically as far as practicable. Two days after the injury (Aug. 14), the temperature was 40° C. (104° F.), and there appeared over the whole surface an exquisite scarlatina eruption, which was intensely red on the next day, and showed numerous milary vesicles. This lasted six days and was followed by lamellar desquamation. Again on Aug. 26 the temperature rose (39.5° C.), and the scarlatiniform rash again appeared, lasting, however, only two days. Decided scaling again followed. Elevated temperature was again noted on Sep. 3d (39.2° C.), and a very characteristic rash again developed, lasted four days, and again desquamation followed. There was at no time angina or swelling of the submaxillary glands. There was no scarlatina in the neighborhood, and no extension of the disease took place. Equally discordant with a theory of scarlatinal origin is the following case reported by Ffolliott:⁴ A private soldier of the garrison of Ali Musjil was burnt in an explosion of gunpowder on the face and arms and on the left hip and internal surface of the thigh. On December 25, four days after the accident, he had considerable constitutional disturbance, and a bright scarlet eruption appeared upon the belly. By the next day his whole body was as red as a boiled lobster. The temperature, at first 101° F., fell as the eruption developed. This disappeared in four or five days and was followed by general desquamation. The disorder was regarded as scarlatina by several medical officers. But the man had been three years in India; there was no scarlatina in camp, and Mr. Ffolliott had not seen or heard of a case in twelve years' service in India. Moreover, scarlet fever is a

¹ Consult also Batut, *Thèse de Paris*, 1882, No. 349.

² It is remarkable that a scarlatiniform rash is apt to follow lithotomy. Thomas Smith saw it seven times in forty-three lithotomies. Maunde, Broadbent, Callender, and others have seen it. Curiously, the rash in these cases often begins around the wound.

³ *Wien. Med. Presse*, 23, 1882, p. 1483.

⁴ *Brit. Med. Journal*, i., 1879.

disease practically unknown in that country.¹ Attempts have been made to establish a differential diagnosis for this surgical rash. Cheadle,² for example, claimed that in "surgical erythema" (1) there is no swelling of the tonsils, no enlargement of the glands, though the fauces may be reddened; (2) the strawberry tongue is absent; (3) the rash is not often universal, but is confined to the body and parts covered with clothes, the face remaining uninvolved; the eruption rarely lasts twenty-four hours, and is never followed by desquamation. These points are of no value. George May, Jr.,³ thought he could diagnosticate the non-scarlatinous surgical eruption by the absence of the boiled-lobster appearance of the skin and by the mild lingual and faucial symptoms. Subsequently, however, he candidly admitted that the case that had served as a text for the expression of this opinion turned out to be one of true scarlatina.

A final etiological factor in the production of scarlatiniform eruptions is the ingestion of various drugs. These eruptions have received from numerous writers passing reference in this connection, but by no means the attention to which they are entitled. Scarlatiniform rashes may be evoked by the ingestion of belladonna, copaiba, opium, and morphia, chloral, mercury, and other drugs, but, above all others, as bearing upon our present subject, of cinchona and its alkaloids. These preparations are those most frequently given to persons who have been injured or subjected to surgical operations, and, beyond question, eruptions induced by them are often attributed to other causes. The quinine eruptions are only beginning to receive due attention, and are much more common than is generally supposed. They usually show the features of urticaria or simple erythema, and are associated with an interesting series of general phenomena. Other eruptive forms are also observed, but the one that concerns us at present is the scarlatiniform rash. This is not especially uncommon, and doubtless many obscure cases of "idiopathic," and "septicæmic," and "surgical" scarlatiniform rash should be properly attributed to it. This rash has been described now by many writers, among whom may be mentioned Bussy,⁴ Levassor,⁵ and, more especially, Morrow.⁶ It may exactly resemble scarlatina. Persons possessing the idiosyncrasy often develop it after even the smallest doses of the drug. At the onset it often cannot be distinguished from scarlatina. Beginning with high fever, and often with sore throat, the eruption appears upon the chest, face, and neck, and within twenty-four hours the entire sur-

¹ Hirsch, "Historisch-Geographische Pathol."

² Brit. Med. Journal, ii., 1879, p. 75.

³ Brit. Med. Journal, ii., 1878, 919.

⁴ Thèse de Paris, 1879.

⁵ Thèse de Paris, 1885.

⁶ New York Med. Journal, xxxi., 1880, p. 244.

face presents the bright scarlet color that resembles that of a boiled crab or lobster. At the end of this period the resemblance may be made perfect by the appearance of the "strawberry tongue." Up to this point, in default of a knowledge of the patient's idiosyncrasy, the diagnosis may remain impossible. Rarely it remains so throughout the attack, especially when the ingestion of the cinchona preparation is continued. Usually, however, after thirty-six to forty-eight hours the type of normal scarlatina is departed from. The fever rapidly decreases; the angina, which has never been proportionate to the other symptoms, disappears, and the rash either begins to fade or to acquire features unlike those of true scarlatina. It becomes duller in color, more papular in character, and often shows a tendency to form miliary vesicles. Eventually, it may come to resemble ordinary "prickly heat." Such a course, however, is by no means always pursued, and the scarlatinoid features are preserved. In either case, a copious desquamation is sure to follow. This is usually lamellar and may show a glove- and slipper-like exfoliation of the epidermis of the hands and feet. Even albuminuria has been known to add to the embarrassment of the diagnostician. The writer has several such cases in mind and is convinced that a closer scrutiny will lessen the number of cases of so-called "idiopathic scarlatiniform erythema," of "septicæmic scarlatiniform rash," and of isolated "surgical scarlatina," by enabling the observer to assign them to their true cause.

The foregoing considerations would seem to justify the following conclusions :

1. Unprotected persons who have suffered injury, or who have undergone surgical operations, are rather more liable to scarlatina than the unprotected healthy. This increased liability is probably due to diminished power of resistance from disease, and will probably hold with regard to other specific fevers. Scarlet fever is more apt than the other exanthemata to attack such persons, because its influence is usually more widespread, and because it varies within such wide limits that it often escapes the attention of those who readily detect other infectious disorders, and provide against them.

2. When an epidemic tendency of the symptoms we have been considering to prevail after injuries and operations is shown, it may be concluded with confidence that true scarlatina is present.

3. Septicæmia is occasionally accompanied by a scarlatiniform rash which does not depend upon the scarlatinal poison.

4. Medicinal eruptions, especially those from cinchona and its preparations, not infrequently follow injuries and operations. These rashes are probably for the most part usually attributed to true scarlatina or septicæmia.

In obstetrical practice, scarlatina is unquestionably capable of exert-

ing a most noxious influence, but as the distinctly scarlatinal symptoms are here decidedly less important than the obscure and dangerous systemic symptoms that the virus seems to induce, the writer does not presume to enter upon the discussion of this branch of the subject before this Association. He inclines strongly to the opinion, however, that in so far as concerns a distinctly scarlatinal rash in these cases, the line of argument followed in this paper is equally applicable.

19 CATHEDRAL ST., BALTIMORE.

THE AMERICAN DERMATOLOGICAL ASSOCIATION.

THE TENTH ANNUAL MEETING, HELD AT GREENWICH, CONN.,
AUGUST 25, 26, AND 27, 1886.

Wednesday—Morning Session.

THE Association was called to order at 10 o'clock by the President, DR. EDWARD WIGGLESWORTH, of Boston, who delivered the opening address, of which the following is an abstract:

GENTLEMEN:—Just ten years ago, at Philadelphia, I had the honor of calling to order the first public meeting for the organization of this Association. Our specialty for the first time received national acknowledgment. Our guerilla warfare was over, and our subsequent record has been one of unbroken successive victories over bigotry, error, and ignorance.

But the day of paladins is past, and our ranks will admit more recruits. There are still remaining opportunities for more extended instruction of students in medical schools, while the lack of hospital facilities for the proper clinical treatment of diseases of the skin is a standing shame and disgrace to our municipal authorities, our hospital boards, and to the medical profession itself. As now arranged nearly everywhere amongst us, these institutions refuse to a large class of sick persons the benefit of hospital residence either wholly, or offer them, if received, not, we may fairly say, the best medical skill it is in their power to procure. Some progress has, however, been made. New York has now a special hospital for skin diseases, besides two wards in the Charity Hospital, and Philadelphia has special clinics, with beds at three different institutions.

That the workers are ready as soon as they shall have opportunity is evident. Ten years ago, our officially recognized representatives were four professors, five clinical professors, one instructor, and six lecturers;

total, sixteen. To-day, we number seventeen professors, eleven clinical professors, six instructors, and sixteen lecturers; total, fifty. Nor do I include genito-urinary surgery, which I regard as a distinct specialty from that of dermatology, which, of course, includes syphilis.

About twice as many cases of diseases of the skin are now annually treated by specialists as there were ten years ago.

The contributions to American dermatological literature during the past decade include the best treatises, hand-books, and atlases, the only periodicals, and some of the best monographs of the time in the English language.

Our sole local organization, the New York Dermatological Society, is as active as ever, and the good work which it has already done is constantly increasing.

Two honorary and three active members of our original Association have passed away since its organization. Twelve active members, all living, have been added to its ranks. So much for our maternal progress and present prosperity.

Other objects of the foundation of our Association have been by no means neglected during the past ten years. There exists to-day a harmony and good feeling amongst us which, but for the personal acquaintanceship resulting from the formation of this Association, never would have existed. We have come into better accord as to the "nature and treatment of skin diseases." Our increased membership proves that our Association is "held as a place of aspiration;" and it has consistently required "independent work in our department" as the essential preliminary step toward the acquisition of such membership. The systematic work of our standing committee upon statistics has already furnished valuable data for comparison, as well as a series of excellent reports upon "Leprosy in America." Concerted official effort has done much, and will do more, to repress the rank luxuriance of growth of dermatological nomenclature, and to furnish a "uniform and simple system."

While much has been accomplished, much still remains to be done. The idea of specialism, already rooted, is to be nurtured and trained in the minds of the profession and of the public, and the practical development socially of our specialty itself is to be elaborated in many minor details. The pioneer must no longer prove a martyr. A knowledge of the weaker side of human nature, useful for selfish financial ends, must no longer be allowed to usurp the province of exact scientific acquaintance with disease, inuring to the benefit of our race. The "elaborate division of labor" is "as useful and successful in a learned profession as it is in the mechanic arts." For it is merely a relative question of height of standard. Specialism substitutes quality for quan-

tity, which substitution is the essential characteristic of the civilized man as distinguished from the savage, while the rapidity of such substitution gauges the progress of civilization itself. Medicine is merely that complex whole which results from the combination of all its component parts, and their individual advancement is the criterion of its own progress.

Science is only exact knowledge. Medicine is that knowledge specially directed to the physical welfare of mankind, and specialism is only that further subdivision rendered necessary by the very various parts composing the individual, and possibly by the extension of our opportunities for studying these parts due to increase of mechanical means for enlargement of the fields of our hitherto unaided senses. No one can to-day "take all knowledge to be his province." Science does not culminate in a Jack-at-all-trades, least of all in one whose conscience has become anæsthetized by custom, who confounds his own limitations with the "limitations of human understanding," and his own ignorance with "the immaturity of medical therapeutics." The specialist builds his own boundary wall, and cannot, if he would, poach upon the preserves of others. He "distinguishes what he can do from what he cannot," thus filling the old definition of the best physician. He cannot maltreat a patient, and when compelled to confess ignorance and seek superior wisdom, charge the wronged sufferer another and still higher fee for a "consultation," which is in reality a confession. It has been sarcastically called "the sole duty nowadays of the family doctor is to decide what specialist shall be summoned." It certainly is his duty, and a very important one, as a man of honor to decide whether any one, and, if so, who can probably accomplish that wherein he admits that he himself has failed. Unfortunately, many know so little that they are even ignorant of how much is known by others; but, in many respects, the specialist has already raised the average standard of requirement for general practice to such an extent that much of the old routine practice of physicians who treated their patients for the very diseases for which they referred members of their own families to the specialist, has now become punishable mal-praxis. But the general practitioner has his revenge in opposing as unnecessary the hospital appointment, and even the private practice of the very specialist to whom he himself flees as "a very present help in time of trouble."

We are told that "the human body is made up of parts and functions so thoroughly independent that it cannot be parcelled out into defined and isolated regions." It can, and it cannot. What scientist divides a country into square miles, and attempts to become thoroughly conversant with every atom existing in each of those miles? The special divisions of study are rather the flora, the fauna, the geological strata,

etc., though all these may pervade identically every mile of the region. If regional surgery is possible, then specialists are certainly not contraindicated. We hear of "appalling pathological conglomerates" due to lack of proper "general medical treatment." Not only "conglomerates," but often single lesions are very variously diagnosed by different general physicians, and the "conglomerates" are usually merely the aggregated effects of original causes which might have been obviated by proper investigation in due season on the part of suitable specialists.

The aforetime "consulting physician" meant one who, in addition to his general acquirements, knew more about some particular thing than any one else. We may be sure that his general acquirements had to pay the penalty. To-day we honestly admit this, and, renouncing the practice obtainable by general acquirements, keep to that particular thing of which we know more than others. No one has mental ability enough at the present time to add to the greatly extended knowledge necessary to the general physician the intensified fundamental acquaintance with details needed by the specialist. Life is too short for the ablest intelligence to exhaust even any one specialty. The physician may, like Newton, "think the thoughts of God after Him," but the thoughts of the Infinite upon the smallest molecule of matter call for more than the limits of a finite existence. The true consulting physician of to-day is the specialist, and he should, therefore, receive this title at the hospitals with which he is connected, while those ex-physicians called consulting, but never consulted, should receive their true and proper title of *emeriti*.

But enough of the "idea of specialism." The public will in time appreciate the absurdity of being content with inferior results in one branch of medicine because, forsooth, there are so many others in which their medical adviser is equally or more at home. It will reason rather that he who "insists upon doing the work of ten men manifests a quality of mind which we can only call arrogance, and which challenges for his work severe criticism." Versatility will not atone for crude and imperfect work, any more than will lack of time, hurry of life, keenness of competition, or financial necessity, and it is merely brazen self-assertion which delights "not so much in doing the thing well as in showing how well he can do it."

Believing in the ultimate achievement of all possibilities and in the progress of truth, I have no doubt as to the future of specialism, if we are honest and earnest. Not infinite omniscience, but infinite morality is the duty of the specialist, and this, conscientiously carried out, will blunt the sharpest dart of the hostile general practitioner. While visions of what yet remains to be accomplished might well lead us almost to despair, a mere glance at the generally prevailing ignorance on the part

of both physicians and their patients shows conclusively that we and our work are imperatively demanded.

Dr. Wigglesworth next considered in detail the duties, in the future, of members of the Association as to the establishment of special skin wards in all general hospitals; as to a revision of the existing nomenclature and classification of skin diseases; as to improvements in the annual reports of transactions; the use of the metric or international decimal system; more extended statistics; the establishment of a permanent committee upon new remedies; the question of fees and the remuneration of physicians by others of the same profession; the desirability of a (proposed) consistent schematic plan for the report of cases, always accompanied by a summary; and the duties of specialists as to instruction. Attention was called to the proposed union of all the special medical associations of America into a general "congress of physicians."

The meeting was then declared open for business.

DR. EDWARD BENNET BRONSON, of New York, read the first paper, which was entitled:

ERYTHANTHEMA SYPHILITICUM.

He reported the case of a syphilitic patient who developed a peculiar eruption on the head, hands, and feet. This presented no pronounced syphilitic characteristics, but it was shortly followed by well-marked specific efflorescences on various parts of the body. The eruption on the head subsequently presented infiltrations distinctly syphilitic. The first appearance of the eruption was in the form of an erythema with a vesiculopapular efflorescence. These subsequently broke, discharging a foul-smelling liquid. Later, vegetating growths, resembling condylomata, made their appearance upon the face. In the course of a week or two, the erythematous patches exhibited a copper-colored infiltration. The patient showed other manifestations of syphilitic disease, which rapidly yielded to mercurial treatment. The preliminary eruption in this case was thought to be an erythanthema dependent upon the specific disease. Its origin is probably similar to that of certain angio-neurotic affections, which it closely resembles. The erythanthema syphiliticum is only an indirect effect of the syphilis, the result of reflex irritation of the skin from the action of the disease upon the nervous centres. It is, therefore, not pathognomonic of syphilis.

DISCUSSION.

DR. I. E. ATKINSON, of Baltimore, said that, while he had seen similar eruptions in syphilitic subjects, they had never occurred in the early stages, but as manifestations of late syphilis and in malignant cases.

DR. JAMES C. WHITE, of Boston, said that, while *à priori* there was

nothing against a causal relation between the eruption and syphilis, the connection had not been proven, and that, in the present state of knowledge, it was better to regard the association as accidental.

DR. F. B. GREENOUGH, of Boston, remarked that the syphilitic roseola was distinguished from all other forms of congestion of the skin by the presence of little points of congestion which represent the follicles. These show for a long time after all congestion has disappeared. The points of pigmentation seen in this form of eruption also are peculiar. The condition seen in the case described was not a common one; and, whether it was due to the syphilis or not, the co-existence of the two is interesting.

The paper was further discussed by DRs. R. W. TAYLOR, A. R. ROBINSON, and G. H. TILDEN.

The next paper was presented by DR. I. E. ATKINSON, of Baltimore, on

RUBELLA OR RÖTHELN.

The author gave an elaborate account of the natural history of the disease, as he had been able to study it from an examination of the reported cases. He referred to the confusion in the nomenclature, and suggested that this affection be termed rubella. For popular use, the expression "epidemic roseola" might be employed.

In discussing this paper,

DR. E. B. BRONSON, of New York, favored the use of the term rubeola to describe this affection, while morbilli was used to indicate measles.

THE PRESIDENT stated that, several years ago, he had proposed a similar nomenclature, morbilli being used to represent measles, rubeola, or rötheln, to represent what is known as German measles, and roseola to represent the simple rose spots as seen in syphilis and other affections.

DR. JAMES C. WHITE, of Boston, objected to the term rubeola being used to describe German measles, because many English and German writers applied this term to measles. He favored the introduction of the new term "rubella."

DR. G. H. FOX, of New York, presented the report of

A CASE OF LYMPHADENOMA (MYCOSIS FONGOÏDE); WITH AUTOPSY.

During the summer of 1881, the patient suffered with general pruritus, which subsequently passed away. Small flattened tumors appeared in the axillæ one year later. The eruption disappeared from these situations and reappeared in other portions of the body. Shortly after her last confinement in February, 1885, a tumor developed over the left scapula.

The patient came under observation six months later, and at this time presented numerous lesions, some of which were ulcerated. The most marked lesions were upon the breasts. Treatment with Fowler's solution and with chaulmoogra oil produced no effect, and the patient

died in April, 1886. The autopsy was made by Dr. A. R. Robinson, who gave the results of his examination.

The next paper was

A NOTE RELATIVE TO THE BULLOUS ERUPTIONS PRODUCED BY IODIDE OF POTASSIUM.¹

By JAMES NEVINS HYDE, M.D., of Chicago.

DR. R. W. TAYLOR, DR. J. E. GRAHAM, and DR. I. E. ATKINSON reported similar cases in which the use of iodide of potassium had produced a bullous eruption of severe type. In all cases the eruption disappeared when the use of the drug was stopped.

Evening Session.

DR. R. W. TAYLOR, of New York, read the first paper, entitled:

PRECOCIOUS GUMMATA.

The speaker described numerous cases which he had studied, and as the result of his investigations he had formed the following conclusions:

1. Like affections of the osseous system, of the nervous system, and like malignant syphilides in general, the gummata syphilitica may be precocious in appearance, occurring as early even as the second month of infection, but usually in the third or fourth month, and beyond that time.

2. Of the precocious gummatus syphilide or gummata, there are three quite clearly marked forms: *a*, the early, general, and copious form; *b*, the more localized form, which may invade several regions, is usually symmetrically distributed, and sometimes even is confined to one region, particularly one side of the face or scalp, and the roof of the mouth; and *c*, a form in which more or less severe neuralgias precede and accompany the eruption, which in many particulars resembles simple erythema nodosum, but which in its etiology is not in any way related to this simple form of eruption, but is a direct outcome of the syphilitic diathesis.

3. That these precocious gummata partake in general of the features of those of a later period, but they differ in the more acute invasion, in a much more rapid course, and are usually not as profound and destructive in their action as the classical eruption.

4. That of these precocious forms of gummata there are found to be two varieties—one a non-ulcerative or resolute, the other an ulcerative variety.

5. That in the treatment of these precocious syphilides, a combination of mercury and iodide of potassium is much more efficacious than is mercury alone.

¹ Will be published in subsequent number of this JOURNAL.

DR. F. B. GREENOUGH, of Boston, followed with an article, entitled:

CLINICAL NOTES ON SCABIES.

The speaker had been surprised at the increased frequency with which the disease presented itself in recent years. While in 1879 he had seen but three cases, yet in 1885 two hundred and seventy-six cases had come under his cognizance. The ratio of cases of scabies to other affections of the skin had increased from three-tenths of one per cent in 1876 to thirteen per cent in the past year. This rapid increase in the number of cases of this affection was explained by the fact that it was often not recognized, and every case not diagnosed proved a focus of contagion for a large circle of cases. The author had found typical burrows in but a few cases. In male subjects, typical lesions are frequently found on the penis, when not seen in other parts of the body. In the treatment, he had obtained perfect results with sulphur ointment.

DR. A. R. ROBINSON suggested as an aid in the diagnosis that the contents of a vesicle be examined with the microscope. The detection of young acari or of the fæces would at once determine the nature of the eruption.

DR. E. B. BRONSON, of New York, in speaking of the treatment, stated that he had used a fifty-per-cent preparation of naphthol, making one thorough application, with satisfactory results.

DR. H. W. STELWAGON, of Philadelphia, presented a paper on

THE VALUE OF RESORCIN, ICHTHYOL, AND LANOLIN IN CUTANEOUS DISEASES,

giving his clinical observations on the use of these drugs. Resorcin had been found of service in tinea sycosis. In seborrhœa, it had always been found beneficial. In one case of superficial epithelioma of the nose, the use of a fifty-per-cent ointment had been followed by healing.

In three cases of furunculus, ichthyol in the form of a twenty-per-cent plaster had acted with good results. In a small proportion of cases of rosacea and acne vulgaris, it was beneficial.

Lanolin was recommended as an ointment base where a certain degree of penetration was desired. Where, however, simply a protective influence is desired, it is less sufficient than other preparations. In a few cases of acute and subacute eczema, lanolin had produced irritation.

Second Day—Morning Session.

TROPHONEUROSIS OF THE SKIN CAUSED BY INJURY OF THE MEDIAN NERVE.¹

By G. H. TILDEN, M.D., of Boston.

¹ See this JOURNAL, page 289.

DR. JAMES C. WHITE, of Boston, read a paper on

NATIVE PLANTS INJURIOUS TO THE SKIN,

in which he gave a detailed description of fifty or more species which were capable, when brought in contact with the skin, of producing irritation varying from a slight erythema to a severe dermatitis.

The paper was discussed by Drs. Sherwell, Piffard, Morrow, Atkinson and Denslow.

DR. H. G. PIFFARD, of New York, presented a paper, entitled:

NOTES ON DRUGS,

giving his observations on a few preparations recently recommended in the treatment of cutaneous diseases.¹

A FEW ADDITIONAL NOTES ON PSORIASIS.

By DR. F. B. GREENOUGH, of Boston.

The paper was a continuation of the tabulation of cases which he had presented to the last meeting of the Association. Further observation had confirmed him in the conclusions which he had then presented. He laid special stress upon the good general health of patients who had come under his notice suffering with psoriasis. He had seen twenty-nine cases out of 1,220 cases of all kinds of skin affections, making a percentage of a little over two and one-third. In estimating the general health, he had marked the patients on a scale of five. The average of the general health of the twenty-nine patients thus examined was four and one-third.

DR. A. R. ROBINSON, of New York, reported a case of

CHONDROMA OF THE UPPER LIP.²

The next paper described a case of

KERATOSIS FOLLICULARIS, ASSOCIATED WITH FISSURING OF THE
TONGUE AND LEUKOPLAKIA BUCCALIS.³

By P. A. MORROW, M.D., of New York.

Evening Session.

A CLINICAL STUDY OF SCLERODERMA.⁴

By J. E. GRAHAM, M.D., of Toronto.

¹ See page 293.

² Will be published in a subsequent number of this JOURNAL.

³ See the JOURNAL for September.

⁴ Will be published in subsequent number.

DR. L. N. DENSLOW, of St. Paul, in discussing the paper, related a case of scleroderma affecting the chest, in which benefit had followed the daily use of the constant current, continued for six months.

CARCINOMA CUTIS.

By LEGRAND N. DENSLOW, M.D., of St. Paul.

The speaker related a case of this affection occurring in a man aged 49 years. He exhibited a plaster cast and drawing showing the condition.

DR. I. E. ATKINSON, of Baltimore, read a paper on

SCARLET-FEVER AND SCARLATINIFORM ERUPTIONS FOLLOWING INJURIES AND OPERATIONS.¹

DR. P. A. MORROW, of New York, remarked that an eruption simulating that of scarlet fever was frequently produced by antipyrine, although, as a rule, it more closely resembles measles. Antiseptic dressings, such as those containing carbolic acid or iodoform, may produce a general scarlatiniform eruption. Reference was also made to the eruption which frequently makes its appearance on the skin of sensitive individuals, especially females, when exposed for examination. This has been termed "doctor's rash."

DR. L. N. DENSLOW, of St. Paul, related the case of a young woman in whom exposure of the skin to sun-light always produced a scarlatinal eruption. This had been carefully tested and found to be the case.

Third Day—Morning Session.

DR. J. E. GRAHAM, of Toronto, exhibited the specimens from a case of *ainhum* affecting the toe.

REMARKS AND QUERIES IN REGARD TO THE RELATIVE FREQUENCY OF MOLES, AND THEIR PATHOLOGICAL CHANGES ON THE FACE.²

By S. SHERWELL, M.D., of Brooklyn.

In discussing this paper, DR. I. E. ATKINSON, of Baltimore, suggested that the prevalence of these growths upon the face might be only apparent, for, in this position, relief is sought for cosmetic reasons, while if the growths occupy portions of the body which are covered, they do not attract attention.

DR. J. C. WHITE, of Boston, thought that these growths were not more frequent on the face than on other portions of the body, but he agreed that when on the face they are much more liable to undergo malignant degeneration.

DR. R. W. TAYLOR, of New York, indorsed the remarks of the reader of the paper with reference to the danger attending the existence of these growths in individuals beyond the age of forty-five years. He also spoke of the danger of malignant degeneration connected with the

¹ See page 295.

² Will be published in a subsequent number.

presence of inflammatory masses on the prepuce in old persons. In all cases these should be removed.

In the absence of the author, the Secretary read a paper describing a case of

EXFOLIATIVE DERMATITIS (PITYRIASIS RUBRA ?), WITH BULLOUS LESIONS.¹

By W. A. HARDAWAY, M.D., of St. Louis.

DR. G. H. TILDEN, of Boston, reported a case of

PROBABLE TUBERCULOSIS OF THE SKIN,

occurring in a child two years of age, who, six months later, developed caries of the vertebræ.

THE TREATMENT OF ACNE BY THE USE OF SOUNDS.

By DR. L. N. DENSLOW, of St. Paul.

At the last meeting of the Association, the speaker had read a paper with this title. He wished now to give a further report of the cases then related. Five cases had been described, four of these, all adults, had remained well. The fifth case, a boy aged 14, had relapsed.

The officers for the ensuing year are as follows:

President, H. G. PIFFARD, M.D., of New York.

Vice-Presidents, F. B. GREENOUGH, M.D., of Boston, and R. B. MORISON, M.D., of Baltimore.

Secretary, G. H. TILDEN, M.D., of Boston.

Treasurer, LEGRAND N. DENSLOW, M.D., of St. Paul.

A committee, consisting of the above-named officers, was appointed to confer with committees from other societies with reference to the organization of a congress of American physicians and surgeons.

The selection of the time and place of the next meeting was left to the Council.

The Association then adjourned.

ANOTHER HERMAPHRODITE.—Among the replies to an advertisement of a musical committee for "a candidate as organist, music-teacher, etc.," was the following one: "Gentlemen—I noticed your advertisement for an organist and music-teacher, either lady or gentleman. Having been both for several years, I offer you my services."—*Exchange*.

¹ Will be published in a subsequent number of this JOURNAL.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

Late Hereditary Syphilis—Fournier.

I CANNOT refrain, in beginning this letter, from calling the attention of my American confrères to the new work just published, from the pen of the eminent professor of dermatology and syphilography of the Paris faculty, M. Fournier.

I do not believe that there exists another treatise on the subject so complete in all respects. It will be impossible for me to give an analysis of the work at this time. It contains, first of all, carefully detailed, all the practical methods by which late hereditary syphilis is to be discovered in children and adults when a history is wanting. It is not necessary for me to dwell upon the practical importance of diagnosis under these conditions. Again, the author describes with care the phases of the disease more especially observed in late hereditary syphilis, and ends with a comparative table of acquired syphilis of infancy. I cannot praise too highly the clearness of style and the originality of certain chapters which contain descriptions entirely new.

The Relations Existing Between Lupus and Tuberculosis.

This eternal question is being always agitated, and still we advance but slowly towards a solution.

Prof. Leloir has been able, by his activity and scientific ardor, to create at Lille a dermatological centre, the influence of which is already manifest. He has just published a new memoir on the subject of lupus and tuberculosis in the *Annales de Dermat. et de Syphil.* He there relates a case in which he has seen "in the clearest way a lupus no lule of the hand become the origin of tubercular lymphangitis with the production of scrofulo-tubercular gummata along the course of the implicated lymphatics, and finally determine, by absorption of the tuberculous virus through the lymphatics of the upper extremity, a pulmonary tuberculosis of the corresponding side." It must be further remarked that in certain cases erysipelatous lymphangitis seems to play an important part in the absorption of tubercular virus. Its appearance is followed, after a longer or shorter lapse of time, by engorgement of the cervical ganglia. Then local and general phenomena supervene, indicative of a deposit of tubercle in the apex of a lung or in some other organ.

Out of eight women suffering from lupus whom the author treated in his service at the St. Sauveur Hospital, five presented incontestable phenomena of pulmonary tuberculosis; of nine men attacked with lupus, five were equally affected with the signs of tubercular deposit in the lungs. Dr. Leloir has further had occasion to examine histologically two cases of well-marked tubercular lupus in non-tuberculous subjects, and he has found (out of a large number of specimens, to be sure) a few scattered tubercle bacilli. Fragments of this lupus tissue introduced into the peritoneal cavity of guinea pigs furnished a series of incurable tuberculosis in six cases. He therefore concludes that true lupus vulgaris is one of the forms of cutaneous tuberculosis.

Treatment of Lupus Vulgaris.

It is well known that at the St. Louis Hospital in Paris two principal methods of treating lupus vulgaris are in vogue. Dr. Vidal employs the surgical method, and more especially the quadrilateral linear scarifications, which, carried out on the principles which he has so forcibly laid down, give, in many cases, results which are truly marvellous, especially in regard to the regularity of the cicatrices. Dr. Besnier, on the contrary, accuses these bloody methods of favoring the general infection of the economy with tubercular virus, and uses only the electro- or galvano-cautery. For my own part, I have practised scarification in private practice and at the hospital in many cases of lupus, and up to the present time have seen no greater rapidity in the evolution of tuberculosis in the cases so treated than in those left to themselves. I am still looking for a case of pulmonary tuberculosis developed in a lupus patient treated by scarifications. I cannot therefore believe in the noxious influence of the scarification treatment of this disease until more amply informed.

The more carefully I look into the matter, the more convinced I become that it is quite often necessary to combine the methods of which I have spoken, in order to effect a cure. This is how I usually proceed with a case. I begin by making a series of linear scarifications, then cross them at right angles, repeating the operation every eight days, and in the intervals I apply to the patches of lupus the *emplâtre de Vigo cum Mercurio*. Very rapid amelioration is thus obtained, but the amelioration after a time is lessened, and I then practise one or two cauterizations with the electro-cautery. In the great majority of cases, the modification of the disease procured is considerable; I then return to scarifications, and so on.

Cauterization is most useful when we have arrived at that period of the disease which in France we call the period of isolated tubercles, that is to say, when there exist small yellowish tubercles disseminated here and there in the cicatrix. We touch them then one by one with the fine red point of the electro-cautery or of the galvano-cautery. In following this mixed method, we obtain much more rapid amelioration than by the method of scarification alone, and I believe cicatrices are better formed than when the cautery alone is used. It is well to wash the part operated upon from time to time with a solution of corrosive sublimate one to a thousand, and to give arsenic internally. I have tried and am still trying in lupus vulgaris applications of salicylic and of pyrogallic acids in collodion (one gram of salicylic acid and five grams of pyrogallic acid to fifty grams of flexile collodion). The effects produced seem to me irregular. The inflammation produced is often too great and too long continued, and in consequence ulcerations are produced which are long in healing, and still the tubercles have not been destroyed so deeply that they are not reproduced. Nevertheless, I cannot forget that Drs. Vidal and Besnier in France and several German dermatologists have obtained quite good results with pyrogallic acid in ointment or plaster, and I intend to follow out my trial of collodion dressings.

Treatment of Erythematous Lupus.

What I can affirm at the present time is, that the collodion of which I have just spoken has given me good results in erythematous lupus, particularly in an old woman who had had for more than twenty-five years an erythematous lupus of the forehead, nose, and face. Care must be exercised over the action of this

drug, and it must be carefully watched. A new layer should not be painted on, and the old one should indeed be removed whenever pus is seen to form between the integument and the dressing. Neglecting this precaution, we may have a very intense inflammation, causing the patient much pain, and producing deep ulcerations. I do not believe that there is one medication which alone can be recommended to the exclusion of all others for erythematous lupus. In determining the respective worth of the various methods of treatment already known to deserve serious consideration (such as pyrogallic acid, pyroligneous acid, vinegar and acetic acid, emplâtre de Vigo, black soap, and scarifications), we must take into account individual susceptibility. One patient will obtain no benefit from the use of the soap, but will at once begin to improve when scarification is begun, and inversely. We should therefore not persist in employing a method which appears to have but little beneficial effect. It happens at times that after using with much success for a period one of the methods mentioned above, the amelioration slackens little by little until it becomes almost imperceptible. If now we persist in using the same treatment, the affection resists, and finishes by tiring out the patience of the patient and of the physician too. As soon as this diminution in the progress of the cure is noted, we must resort to the other means at our disposal, and among them we are sure to find one which will act beneficially. The period of favorable action having passed—and this is very variable according to the subject and the method—we can come back to the first treatment employed which will usually again give excellent results.

I am convinced, for my part, that scarifications made to cross, and as near to each other as possible, constitute the best possible treatment that we have against this affection, but I also believe that in many cases, if this is the only treatment, and is continually employed, a positive cure can, with difficulty, be effected. The cure will be easily obtained, on the contrary, if we cease for a time the scarification to employ some other method. Besides, scarification is not always possible, either because the patient cannot secure the services of a specialist, or because he is unwilling to go to the expense, or because the disease is too extensive, and it is for this reason that I have recently recommended in the treatment of erythematous lupus the mixture of yolk of egg and vinegar.

This is used either as an application made with equal parts of fresh yolk of egg and ordinary vinegar, and allowed to macerate for twenty-four hours, or a paste is made of the hard-boiled yolk triturated with vinegar, and macerated for several hours. Acetic acid may be added if necessary, if it is found that this paste is not strong enough. The consistence should be such that it can be spread easily on flannel without running; it is to be applied during the night to the affected part. I have in no wise endeavored to find in this topic a specific for erythematous lupus, but regard it as a practical, convenient treatment, free from danger, and one whose effects can be graduated at will by the addition of acetic acid, so as to obtain the degree of inflammation necessary. The patient can employ it without fear in the absence of the physician, and can alternate it with applications of black soap plaster; applications which, to my mind, furnish the most energetic method of treatment after the quadrilateral linear scarifications. After this application has been made for some time, it can be replaced with black soap plaster, to be applied again. It will be found that this interruption of the egg and vinegar dressings renders them more efficacious when begun again.

This method has the further advantage of being so cheap that it is within the

reach of all. It is well understood that, should inflammatory manifestations become too violent, the dressings are to be suspended, and potato-starch poultices applied cold, or vaseline smeared over the part until treatment can be continued.

The following is the treatment I have seen Dr. Besnier employ in erythematous lupus: He first scrapes the diseased portion with the sharp spoon, then he makes repeated cauterizations of the scar tissue with the solid stick of nitrate of silver, and finally passes over it with a stick of zinc. He finds that this treatment brings about a rapid cure. I fear, however, that the cicatrices thus obtained are not so perfect as those formed after the methods of which I have just spoken.

Treatment of Superficial Epithelioma.

The author just mentioned has treated superficial epitheliomata for some time with the electro-cautery, being careful to pass beyond the limits of the disease, both on the surface and in the deeper parts. He then applies a simple dressing until complete cicatrization. Dr. Vidal has, for a long time, been in the habit of scraping out these epitheliomata and, after carefully removing all tissue that would break down under the curette, to cauterize the wound with pure pulverized chlorate of potash, and subsequently dress with tarlatan soaked in a concentrated solution of the chlorate of potash. I have obtained several remarkable cures in this way. I cannot understand why it is that this treatment has not become more common, and is not more employed in France.

Treatment of Syphilitic Phagedenism.

Dr. Vidal has very recently found another application besides the chlorate of potash. There was in his service at the St. Louis Hospital in Paris a young man who was greatly addicted to the use of alcohol, and who had contracted syphilis some months before. Notwithstanding the general treatment which he had received, the cutaneous lesions did not heal, but presented a bad appearance, ulcerated, and became phagedenic. They extended both upon the surface and in depth, with great rapidity. Emplâtre de Vigo, red plaster (containing minium and cinnabar), iodoform, etc., not having any effect, Dr. Vidal conceived the idea of dressing the ulcerations with powdered chlorate of potash first, and then with absorbent cotton soaked in concentrated solution of chlorate of potash, and covered with adhesive plasters. The phagedenism was arrested, and the patient got well. It is true that since then Dr. Vidal has unsuccessfully tried the chlorate of potash in the simple phagedenic chancre. Pyrogallic acid gives him the best results in the latter affection.

In an article which appeared in the *Annales de Dermat. et de Syph.*, Dr. Spillmann remarks that phagedenism, whether it occur on syphilitic lesions or simple chancres, is in great part due to a peripheric infiltration of new elements, and of colonies of microbes which compress the vessels, and thus cause a loss of vitality in the tissues. He has succeeded in stopping this process by destroying this zone of infiltration with the sharp spoon or cutting curette, then excising the loosened borders with curved scissors, cauterizing with the thermo-cautery, and dressing with corrosive-sublimate solution. He thus transforms the serpiginous, fungous, gray-colored lesion of phagedenism into a well-conditioned wound, capable of rapidly healing.

Treatment of Melanodermata.

Prof. Leloir, of Lille, gives, in the *Journal de Connaissances Méd.*, July, 1886,

a treatment for melanodermata which has succeeded well in his hands. He has employed it in a large number of cases of pigmentation of various origin, and even in three cases of flat pigmentary nævus (nævus spilosus) and in two pigmentary nævi as large as a five-franc piece. In these various cases he obtained a rapid cure. This is the mode of procedure: After having first thoroughly cleansed the part with a soft potash soap, or simply with alcohol, he applies several layers of the following application: chloroform, 100 parts; chrysophanic acid, 15 parts; and when this coat has dried, he covers it with a layer of traumaticine; that is to say, gutta-percha dissolved in chloroform. When the adherent pellicle is detached, a new application is made, and so on.

In two cases of pigmentary nævus, the author has first treated the spots with salicylic ointment, and he thinks thus to have rendered the action of the chrysophanic acid more efficacious. It must be remarked that this treatment can only do good in epithelial melanoderms, and not in those which depend on a deposit in the interior of the derm itself.

L. BROCC.

PARIS.

Selections.

THE INTERNAL TREATMENT OF GONORRHŒA.

At the meeting of June 21st, of the Berlin Society of Internal Medicine, a discussion arose upon the treatment of gonorrhœa by medicines.

Dr. Posner stated that, although what had been learned about the gonococcus was extremely interesting, it had not given us much that was practical so far as treatment was concerned.

Local anti-bacterian treatment has not yet been followed by brilliant results, and to-day we treat gonorrhœa with the well-known remedies, and combat it especially with the various forms of injection. These injections are not valuable in that they destroy the gonococci, but because they cure the inflammation of the mucous membrane. Internal medicines act beneficially by passing off in the urine and clean out the urethra in the opposite direction from that in which local treatment acts.

He speaks highly of sandal-wood oil, which has had such a reputation in France, and which he has used much because he has become convinced that injections, although they work so well in some stages of gonorrhœa, still are not well borne by many patients, and can indeed act injuriously. From the speaker's observation he believes that many gonorrhœas which would get well of themselves under suitable regime are often kept up artificially.

He has used the sandal wood in fresh cases, and can state from his own observations that under all circumstances it was better borne than the other balsams, and that under all conditions it exerted a better influence on the disease.

In those complications of gonorrhœa in which we have to cease injections, on account of epididymitis, cystitis, prostatitis, etc., this drug is greatly to be recommended.

Repeatedly had Dr. Posner seen cases of acute catarrh of the bladder, with bloody or turbid urine, improve and the urine become clear after a few doses

of the sandal-wood oil. In old cases of cystitis and prostatitis, it is also beneficial and always acts favorably on the tenesmus, and clears up the urine. In chronic gonorrhœa, less stress is laid upon its beneficial action. The purity of the preparation is of great importance. The most elegant form to use is the French preparation which goes under the name of "santal midi," put up in capsules which are easily taken and well borne. The patient takes daily from ten to twelve of the capsules of five drops each. A German preparation on the market, also in capsules, does not agree so well with the stomach. If the oil does not agree with the patient, a little hydrochloric acid may be added to the dose, and, to improve its taste, a few drops of oil of peppermint.

Altogether, according to the speaker's idea, sandal-wood oil is the most efficacious internal remedy at our disposal.

Dr. Lublinski has had occasion to use sandal wood since his attention was called to it from English sources, some four years ago, and he agreed with Dr. Posner as to its value. It does not affect the stomach nearly so much as balsam of copaiba, but its action is not so strong as the latter drug. He has increased the daily dose gradually to twenty capsules. When administered in drops, he gives peppermint tablets with it. In severe tenesmus, even when the bladder is affected, he has found it to work admirably.

Dr. Rosenthal had also used sandal wood, but when a decided result was not obtained, he was better satisfied with the old balsam of copaiba. It is desirable to have the drug remain as long as possible in contact with the mucous membrane of the urethra. When the disease is in the posterior part of the urethra, in the neighborhood of the neck of the bladder, balsam of copaiba has an especially favorable action, but if the gonorrhœa is in its first stage the result is not so good. He does not altogether agree with Dr. Posner that no injections are necessary. That balsam of copaiba has an action on the gonococci is shown by a recent work of Oppenheimer. The gonococcus does not grow when placed in the urine of a man who has been taking the balsam. When gonorrhœa reaches the neck of the bladder all injections must be withheld, and at this time he has found balsam of copaiba the best remedy.

Dr. Caspar also confirmed in all essentials Dr. Posner's observations. He had first learned of the use of the drug in England two years ago, and had since made frequent use of it. He finds, however, the dose given by Posner rather large, and uses himself only a ten-drop dose three times daily. The East India sandalwood is that most to be recommended.—*Deutsche Med. Zeit.*, July 1, 1886.

ECZEMA OF THE NARES.

IN the July number of this JOURNAL will be found an article on *Excoriationes Narium*, giving the conclusions of a paper by Dr. Schmiegelow. This troublesome affection has deservedly received considerable attention of late, in connection with eczema, suppuration of the interior of the nostril, and allied diseases.

Dr. Kiesselbach has an article in the *Monatsch. für Ohrenheilk.*, 1885, No. 2. He says that the external skin of the nose, instead of stopping short at the entrance to the nostril, reaches up to the upper edge of the *alæ nasi*, and almost to the anterior edge of the lower cartilage and cartilaginous septum; thus diseases of this portion are in reality skin diseases. Eczema of this region, which is the commonest disease met with, depends upon an acute or chronic rhinitis, as a rule, but in its development and course acts entirely like the various forms of eczema found on other parts, excepting that here is rarely to be discovered the outbreak

of vesicles. The continual irritation quickly produces crops of pustules and rhagades soon form. The acute forms get well rapidly upon the disappearance of the exciting acute rhinitis, but if they become chronic they remain most obstinately upon the parts about the floor of the nostril and on the inner walls of the tip of the nose, and occasion various disorders, among which the author especially mentions scrofulous hyperplasia of the upper lip, reddening of the skin of the nose, and predisposition to recurrent erysipelas of the face. As treatment he recommends in the acute form simply some non-irritating fatty protective. In the chronic form, Hebra's diachylon ointment, or white precipitate salve, spread over the parts with the aid of a glass rod.

In No. 5 of the same journal, Dr. Moldenhauer says that we have to deal with two diseases of the entrance of the nostril which are distinctly separate, both pathologically and clinically. 1st. Eczema, which is mostly encountered in children having some signs of scrofula, especially when the surrounding parts about the nostril and lip are implicated, and 2d, sycosis, which occurs as a suppurating folliculitis of the hair sac in the skin of the tip of the nose by preference, while here, even in women, are found thick, stiff hairs.

The treatment given consists in epilation, where it is necessary, puncturing of the pustules, scarification where there is much infiltration of the skin, and the employment of emollient local baths for the nose.

Another article occurs in the same number of the journal mentioned, giving the views of Dr. Baumgarten, of Budapest, who advises in cases where the skin is much infiltrated and covered with thick crusts, to epilate the large hairs and to rub into the part with a pledget of cotton some white precipitate ointment, so as to make it penetrate the skin and cause it to become more pliable.

ELECTROTHERAPY IN A CASE OF ANGIONEUROTIC BULLOUS EXANTHEMA.

DR. VON BREDA reports the following case in the *Giornale Italiano delle mal. ven. e delle pelle*, March, 1885.

A married lady of 22, slightly anæmic, but otherwise healthy, presented an afebrile exanthem, attended with severe pain in one spot, which increased on motion, was neuralgic in character, and extended to the point at which the eruption appeared three or four days later. The painful region now began to swell, and an eruption similar to that in erythema annulare appeared, and advanced from the periphery towards the centre. The pain increased, until finally small vesicles formed at the edge of the affected spot. These soon became confluent, formed a ring of vesicles, and finally a bulla from advancement toward the centre. Such eruptions quickly appeared in great numbers upon the upper and lower extremities.

The galvanic current, with the anode at the back of the neck and the cathode on the affected region, greatly diminished the pain and aborted the attack.

A relapse was treated by the method of Beard and Rockwell: the positive pole on the back and the negative in the water of a lukewarm foot-bath, in which the patient's feet were placed.

SYPHILITIC EPILEPSY AND ITS DIFFERENTIAL DIAGNOSIS FROM ORDINARY EPILEPSY.

1. SYPHILITIC epilepsy manifests itself not only by epileptic phenomena, but by attacks which are such a faithful reproduction of the clinical picture of ner-

vous epilepsy that it is absolutely impossible to differentiate the one from the other.

2. It is not due to a special virus, as was taught twenty years ago, but to cerebral and medullary lesions.

3. It is distinguished from essential epilepsy: 1st. By the absence of the cry or the aura, by the mode of succession or apparition of its crises, by the age of the patient, by the cerebral troubles, precocious or late, preceding or following the attacks (cephalgia, vertigo, fainting, Jacksonian epilepsy)—all characters of a secondary order as regards this diagnostic value, since they are common both to epilepsy symptomatic of a syphilitic lesion and of an ordinary tumor of the brain. 2d. By the frequent co-existence of disorders of sensation in the limbs, especially the lower limbs, and by the frequent abolition of the tendon reflexes—phenomena which possess a real importance from a diagnostic point of view, since they are wanting in ordinary epilepsy, while they are quite frequent in syphilitic epilepsy; in the latter case, the brain and cord are simultaneously affected by the specific disease. 3d. By the effects of mercurial and iodide treatment.—DR. BARBIER, *Th. de Paris*.

ZINC OXIDE IN THE TREATMENT OF CHRONIC SPECIFIC URETHRITIS.

DR. BALL, of Albany, speaks highly of the use of zinc ointment in the treatment of chronic urethritis. In fifteen cases in which this remedy was employed, the average duration of the treatment was a little over four weeks; the shortest was ten days, the longest eight weeks. The ointment is made according to the following formula: \mathcal{R} Zinci oxid., 3 iij.; Adipis, 3 iij.; Cerati simpl., 3 ij. M.

A moderately sized, olive-pointed bougie is selected; the constricted portion of the bougie is filled out evenly, and as smoothly as possible with the full calibre of the instrument by means of the ointment, which adheres readily. The bougie is carried down to the prostatic portion of the urethra as rapidly as possible, and then, after rotating, it should be slightly withdrawn, and pushed back again. The remaining portion of the urethra should be similarly treated, giving plenty of time for the ointment to be melted, and left in contact with the diseased membrane. The applications should be made at least twice a day, in the morning and just before retiring. The patient should be instructed to empty his bladder previous to the application, and refrain from doing so again as long as possible.—*Albany Medical Annals*, June, 1886.

CLINICAL STUDY OF MOLLUSCUM PENDULOSUM.

1. MOLLUSCUM is a tumor due to circumscribed hypertrophy of the derma, a sort of local elephantiasis, the fibrous tissue predominating in the derma; the tumor is therefore essentially fibrous.

2. The tumors may be disseminated over the entire surface of the body, or localized in certain points. The first variety may be classed under the term molluscoid diathesis or generalized molluscum; the second variety may be classed as localized molluscum, and is generally pediculated.

3. These two varieties of molluscum, although anatomically allied, should be regarded as absolutely distinct from a clinical point of view.

4. The labium majus and the inguinal crease constitute the seat of predilection of molluscum pendulosum as well as of elephantiasis.

5. The elastic ligature should be preferred to all procedures for the removal

of pediculated tumors. Practically, it is convenient, but slightly painful, does not frighten the patient, and puts at rest all fears of hemorrhage.—DR. M. BARRY, *Th. de Paris*.

THE EMPLOYMENT OF THE EMPYREUMATIC OIL OF THE YELLOW OF EGGS AS A DRESSING.

REFERENCE has been made in this JOURNAL to Dr. Brocq's treatment of lupus erythematosus with a mixture of vinegar and the yellow of eggs. M. Fremm has employed the empyreumatic oil obtained from the yolks as an antiseptic dressing to ulcers and ulcerous wounds with excellent results.

In one of his cases, three of the ulcers occupied the postero-external region of the middle of the thigh; in three others (a, b, c), the antero-external region of the right thigh; they were all of the same dimension, that of a fifty centimes piece.

May 23, M. Fremm dressed two of the ulcers, a and b, with the empyreumatic oil, the ulcer c with iodoform, the three others with phenic acid, one to forty.

The dressings were renewed every second day. On May 29, after three dressings, the ulcers a and b were partly filled up and almost healed; the ulcer c was reddish, but almost of the same extent as on the 23d; while of the three ulcers dressed with phenic acid, one was slightly improved, while the others were indolent, grayish, and without evidence of reparative granulations.

During six months past, the empyreumatic oil was then daily employed in the military hospital of Bordeaux, in numerous cases of wounds, ulcers, abscess, and also in gonorrhoea, with the most satisfactory results.

The oil is obtained by separating the albumen, and cooking the yolks for forty minutes. The oil obtained is of a brownish color; the odor of burned organic matters, burned horn; the taste (at first slightly sweetish) excessively bitter; syrupy consistence; neutral reaction; density 0.986.—DR. OGER, in *Jour. de Méd. de Paris*, Aug. 15, 1886.

LEPRA TUBEROSA.

THE following are some of the conclusions of a paper on lepra, from the pen of Unna (*Centralblatt für die Ges. Therapie*, Nov., 1885).

1. Lepra tuberosa is curable.
2. The cure can be effected in a comparatively short time by the energetic employment of reducing agents, internally and externally.
3. Among such agents are especially to be recommended, ammonium sulpho-ichthyolicum (ichthyol), chrysarobin, pyrogallol, and resorcin.
4. Ichthyol must be used externally, in very concentrated form. Internally one gram per day will suffice.
5. Resorcin is a useful drug, rendering good service in form of salve and plaster, and recommended where more powerful agents are contraindicated.
6. Pyrogallol is a powerful drug against lepra, and should only be employed in form of a five-per-cent salve.
7. Chrysarobin is perhaps the most efficacious outward application, but in lepra more than in other diseases, the danger of causing conjunctival irritation prevents its exclusive employment.

Items.

NOTICE.—THE CHROMO-LITHOGRAPH designed for the October number, will appear in the November number of this JOURNAL.

AMERICAN DERMATOLOGICAL ASSOCIATION.—At its recent meeting at Greenwich, this Association resolved to issue an invitation to foreign dermatologists to attend its meeting next year, and present papers and take part in the proceedings. The meeting will be held early in September, but the time and place have not yet been definitely determined.

CAN A MAN HAVE A FEMALE COMPLAINT?—A young man entered the Dispensary of the Chicago Polyclinic recently, and going up to the clerk held out one of the Dispensary circulars, with the question: "Say! isn't this the hour for diseases of women?" The clerk answered in the affirmative, when the young man said: "Well! I've got a disease of a woman and want to be treated."—*Jour. Am. Med. Ass'n.*

SCIENTIFIC INQUIRY.—At a local medical meeting a country child of ten der years having an anomalous skin eruption was shown. There was some suspicion that it had a specific origin. An inquirer, more enthusiastic than discriminating, asked the child: "Has your mother ever had any mis-carriages?" "No, sir," she said; "mother has always took around her vegetables in a donkey-cart."—*Exchange.*

MIXTURE TO STOP FALLING OF THE HAIR AFTER TYPHOID FEVER (Bouchard).—

R Ol. Ricini.....	7 grams.
Goudron	2 "
Tinct. Benzoini.....	20 "
Chloroformi.....	30 "
Alcohol.....	1,000 "

—*Le Concours Médicale.*

TREATMENT OF ALOPECIA (Bartholow).—

R Fl. Ext. Pilocarpi.....	1 part.
Tinct. Cantharides.....	1 "
Liniment. Saponis	2 parts.

M.

—*Colleg. and Clin. Record.*

PARASITIC SKIN DISEASES (Bartholow).—

R Picrotoxin.....	grs. x.
Benzoinated Mutton-suet.....	$\frac{2}{3}$ i.

M.

—*Ibid.*

INCONTINENCE OF URINE (Bartholow).—

R Ext. Ergotæ.....	gr. i.
Ext. Nucis Vomicae	gr. $\frac{1}{6}$.
Ext. Belladonnæ.....	gr. $\frac{1}{8}$.

Fiat Pil. Sig. Take three times a day.

—*Ibid.*



Dr. Morrow's Case of Faria.

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Original Communications.

REPORT OF A CASE OF FAVUS (TINEA FAVOSA), WITH REMARKS ON THE TREATMENT OF THE TINEAS.

BY

PRINCE A. MORROW, A.M., M.D.,

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THE following case of favus is interesting on account of the unusual development and long persistence of the disease.

The patient, an Italian boy, was brought to me by Dr. J. E. Attinelli, Attending Physician to the Italian Class, New York Dispensary, with the following history.

"The boy, Domenico Muccia, æt. 13 years, was born in the town of San File, province of Basiliatica, Naples, and has been afflicted with the disease nine years. Nicola, his father, was twice married; by his first wife he had one son, Fizio, who was placed out to nurse. Several of the children of this nurse were affected with favus which is quite prevalent in this locality, from whom Fizio acquired the disease.

"By the second wife he had nine children, all of whom contracted the disease from Fizio. These children appear to have been cured by epilation and inunctions, with the exception of Domenico. In his case, the disease proved entirely intractable, and the father sent him to New York, to the care of a maternal aunt, in the hope that he might be cured.

"On June 25, he presented himself at the New York Dispensary. A diagnosis of favus was made, and he was referred to Dr. Morrow for advice and treatment."

Upon examination, June 28, the disease was found to be distributed over the head, the left upper arm, the lateral surface of thighs and legs below the knee, and the internal surface of buttocks, near the anus. The patient indicated various other portions of the body which had formerly been occupied by the disease, but from which it had disappeared.

Almost the entire hairy scalp was found to be seat of the disease. Scattered over the scalp were numerous, variously sized, cup-shaped, yellow crusts, the depressed centre of each perforated by a hair.

Over the vertical region there were two or three irregularly shaped concretions formed by the coalescence of the favi, which still retained their cup-shaped character. The ridgy borders of these patches were elevated one-eighth of an inch or more above the surface, the centres somewhat hollowed.

The hair was quite thin, and in many places, especially over the vertex, there was complete alopecia. The peculiar "mousey" odor exhaled by the crusts was quite pathognomonic. Over the left deltoid region, at the insertion of the deltoid, and on the lateral and posterior surface of the arm extending nearly to the elbow, there were a number of rounded, irregularly shaped concretions formed by the fusion of contiguous scutula, which had lost their distinctive shape, constituting the condition known as *favosa squarrosa*. These concretions were admirably shown in the photograph from which the accompanying picture was made.

The lateral borders of these crusts were firm and unbroken, rising fully one-half an inch above the niveau, and of a clear sulphur yellow. On the surface the crusts were disintegrated, somewhat friable, and presenting the appearance of whitish-yellow mortar.

The patches on lower extremities presented the same general characteristics, but were of smaller proportions.

The patch near the margin of the anus was evidently of more recent development. It was composed of a number of lesions concentrically arranged, which in color and shape were most characteristic.

The patient was sent to Charity Hospital, and the treatment was carried out under the direction of my colleague, Dr. Bronson, who was then on duty.

After removal of the crusts and epilation of the diseased hairs, an ointment of chrysarobin was rubbed into the scalp, and a solution of the bichloride (grs. iv. to \bar{z} i.) was applied to the patches on the body. The affected surfaces were also ordered to be washed with green soap.

August 10, the following ointment was ordered: \mathcal{R} *Acidi salicylici*, \bar{z} ij.; *Chrysarobini*, \bar{z} ij.; *Pulv. cretæ*, \bar{z} iiss.; *Vaselini*, \bar{z} ij. M. Rub in for fifteen minutes at night.

September 5. When my service began, the disease had entirely disappeared from the body, leaving as traces slight pigmentations which mark the seat of the lesions. The hairy scalp is clear, with the exception of one or two small pustules. The region of the vertex is almost completely bald, only a few scattered hairs are seen. Owing to the atrophy or destruction of the glandular structures, the portion of the scalp denuded of hair is thin and glistening, presenting the appearance of a tensely drawn piece of parchment.

October 1. The disease is apparently cured. A dressing of carbolyzed vaseline was ordered, and the patient kept under observation to watch for signs of a possible outcropping of the disease.

The history of the treatment of the class of diseases comprehended under the general term "tinea," through its various phases of charlatanry and empiricism until it came to be established on a scientific basis by Bazin, forms one of the most curious and interesting chapters in medicine.

All rational treatment of the present day has for its object the destruction of the offending parasite by topical means, and varies only in the choice of the agents used, and in the mechanical details of its execution.

In the treatment of tineas affecting the general surface of the body, the treatment is simple and usually promptly efficacious. It consists in the use of parasiticides or irritants which destroy the spores, or cause exfoliation of the epidermic structures in which they find a lodgment.

In the treatment of tineas affecting the hairy regions, more particularly the scalp, the problem is complicated by causes purely physical. Instead of the spores being confined to the superficial epidermis and readily accessible to our remedies, they have penetrated to the depths of the hair follicles and even into the substance of the hairs themselves, and within this secure retreat they vegetate into luxuriant growth and defy dislodgment. The disease is obstinate to treatment on account of the mechanical difficulty of bringing parasitocidal agents into immediate contact with the parasite, to overcome which various measures have been employed.

The treatment of favus and ringworm of the scalp does not differ essentially in principle or detail. The first step is the removal of all crusts or scales from the affected surfaces. This may be accomplished by a thorough soaking with olive or linseed oil, or the application of emollient poultices. After removal of all extraneous matters and thorough cleansing of the affected surfaces with soap and water, the hairs should be cut, either with the scissors or a pair of barber's clippers. The razor should never be used, as, according to Besnier, it is the frequent cause of auto-inoculation.

The next step in the treatment is the extraction of all the hairs in the area of the diseased patches. Although many authorities depreciate the importance of epilation, or reject it altogether as an unnecessary, painful procedure, yet it must be regarded as a most essential part of the treatment, especially in advanced or chronic cases. It subserves the double purpose of removing the mass of spores contained in the diseased hairs, while

leaving the orifices of the follicles open, and thus furnishing a more ready entrance to the parasiticial agent.

For this procedure a good epilating forceps with smooth blades should be employed. The use of the calotte or the epilating sticks is too barbarously painful to be recommended. In ringworm of the scalp, the texture of the hairs is so altered from the abundant infiltration of their substance with the fungus that they easily break off, and frequent repetition of the epilation over the same area may be necessary. In favus the hairs are less brittle and more firmly implanted, so that the process of epilation is less tedious to the physician, but more painful to the patient. It is always well to remove the healthy hairs in a narrow zone immediately surrounding the patches, thus limiting their peripheric extension. In order to accelerate the spontaneous elimination of the diseased hairs by provoking a certain amount of irritation, M. Feulard, in his recent work, "*Teigne et Teigneux*," recommends touching the diseased patches with a little crystallizable acetic acid, pure or mixed with chloroform. The applications are to be made with care and at sufficiently long intervals so as not to cause too much irritation.

Immediately after epilation, the parasiticial preparation should be applied. A vast number of agents have been recommended for this purpose, as bichloride and sulphate of mercury, iodine, naphthol, thymol, acetic, boracic, carbolic, chrysophanic, pyrogallie, pyroligneous, salicylic, sulphurous acids, oil of cade, oil of turpentine, croton oil, etc., etc. Success depends, however, less upon the choice of the agent than upon the thoroughness with which the details of treatment are carried out. Equally numerous have been the preparations employed, as aqueous, alcoholic, ethereal solutions, ointments, oleates, collodion and traumaticin combinations, etc.

One of the most efficient parasiticides is a lotion of corrosive sublimate (one or two grains to the ounce), which may be applied by means of a small brush or a piece of flannel dipped in the solution. At night the scalp should be washed with the tincture of green soap and warm water. Should the treatment provoke pustular or other irritation, it must be suspended and emollient applications, or a lotion of hyposulphite of soda (thirty grains to the ounce of water, with a little glycerin) be employed until the irritation subsides. After a few days of this treatment, ointments, or other forms of application, may, with advantage, be substituted for the lotion.

Hardy recommends frictions night and morning with an ointment of thirty to forty grains of flowers of sulphur and fifteen grains of camphor to the ounce of lard. Bazin prefers an ointment of fifteen to thirty grains of turpeth mineral to the ounce. Fox uses, after epilation, a two to five per cent solution of salicylic acid in alcohol or castor oil. Lailler

recommends the continuous applications of compresses saturated with sublimated glycerin.

According to my experience, an ointment of chrysarobin, ten per cent, and salicylic acid, five per cent, is one of the most efficient topical applications. I prefer to use these drugs, singly or in combination, in collodion or traumaticin, forming a fixed impermeable dressing which may be renewed whenever it begins to crack or lift up from the surface. This dressing possesses the advantages of maintaining the active agent in continuous contact, while excluding the air; a supply of oxygen being regarded as essential to the life of a vegetable parasite. Used in this way, general staining of the hair, the production of chrysophanic conjunctivitis from transference of particles of the drug to the eyes, and other attendant disadvantages are obviated. Pyrogallic acid, five per cent; iodine, five to ten per cent, and other active agents may be employed in these combinations. Coster's paste (iodine, 3 i., to colorless oil of tar, 3 iv.) and an ointment of the oleate of mercury, five to ten per cent, are also efficient as parasitocides.

Active treatment should be suspended from time to time in order to ascertain whether a cure has been effected. Should clinical or microscopic evidences of the disease be again manifest, a second or even third series of epilations, followed by parasiticide applications, should be employed until a complete cure is obtained.

As a general rule, it will be found that the readiness with which the disease responds to treatment is directly proportionate to its chronicity and the consequent deep diffusion of the spores.

In the treatment of tinea, as before intimated, there is a wide field for the selection of remedies. Experimentation has not only been active in testing their parasitocidal action, but also in devising expedients for bringing them in direct contact with the microphyte. Ether has been recommended as a menstruum on account of its property of dissolving fatty matter; chloroform on account of its power of penetration; lanolin on account of the facility with which it is absorbed, etc. Harrison has recently recommended iodide of potassium in liquor potassæ for softening the hairs, and the subsequent application of a mercuric bichloride solution, on the theory that it readily penetrates to the roots of the hairs, and a chemical action takes place, resulting in the formation of the biniodide of mercury, which destroys the fungus. These, and many other methods which have little but their ingenuity to recommend them, have been referred to in previous numbers of this JOURNAL. The treatment outlined above will probably prove as efficient as any that may be adopted.

One caution should be observed in the selection of a parasiticide, which is, that it should never be of such strength as to cause destruction of the tissues themselves. The intense dermatitis determined by certain

irritants may produce a permanent alopecia, which favus rarely, and tinea tonsurans never occasions. Ladriet's treatment of tinea with croton-oil pencils, which has for its object the production of an artificial kerion by setting up a suppurative inflammation of the hair follicles, is on this account to be condemned. Cramoisy's treatment by pyroligneous acid, the use of glacial acetic acid, blistering the scalp, and other severe measures are likewise objectionable. It is well, also, to remember that the susceptibility of the scalp to irritants varies in different individuals, and the strength of the application in each case should be measured by the reaction produced.

In the treatment of tinea affecting the beard, the same general principles of treatment obtain. Epilation, with the use of an ointment of iodide of sulphur (thirty or forty grains to the ounce), I have found most serviceable. Good results may also be obtained from the use of an ointment of the oleate of copper or mercury (ten per cent). In eczema marginatum, the use of sulphurous acid diluted one-half, painting the affected surfaces with chrysarobin in traumaticin (ten per cent) or iodized collodion (tincture of iodine and collodion equal parts), as recommended by Piffard, will be found efficient. The use of the bichloride in tinct. benzoin (2 grs. to $\frac{5}{8}$ i.), as recommended by Taylor, is also a convenient and efficient application.

The treatment of tinea versicolor is usually more promptly efficacious than that of other vegetable parasitic diseases of the skin. Energetic frictions with tincture of green soap, repeated for several days, are often alone sufficient. Painting with tincture of iodine, or the use of chrysarobin, pyrogallol, or salicylic acid in traumaticin or collodion, readily removes the superficial epidermis in which the microsporon has its seat.

60 W. 40TH ST.

CLINICAL NOTES ON THE VALUE OF RESORCIN, ICHTHYOL, AND LANOLIN IN CUTANEOUS DISEASES.¹

BY

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RESORCIN: Employed in 25 cases of eczema, 5 cases of trichophytina, 3 cases of tinea versicolor, 6 cases of leg ulcer, 20 cases of seborrhœa and alopecia, 5 cases of psoriasis, 2 cases of sycosis, 1 case of lupus erythematosus, and 1 case of favus; total, 68 cases. In eczema,

¹ Read at Tenth Annual Meeting of American Dermatological Association.

the remedy at times acts satisfactorily; but in the greater number of cases it aggravates. It seems to act best in eczema rubrum, and when the disease is upon the lower extremities. It should not be prescribed in greater strength than a ten-per-cent ointment—in fact, rarely more than thirty grains to the ounce. If applied in greater proportion, there is but one result, and that is, marked aggravation of the disease. In erythematous eczema also, it occasionally has a good effect. While a few cases of eczema were permanently relieved by this remedy alone, such a result is exceptional. It is more in the power that resorcin appears to have in controlling the itching that its advantage is seen. In this respect, it seems with present limited experience to be an addition to the therapeutics of eczema.

Of the five cases of trichophytina, two were ringworm of the bearded region, and the remaining three of the scalp. Of tinea sycosis, both cases were of moderate degree: cure was effected in one case in three weeks; in the other, the result was good, but it required a longer period to secure it. In the three cases of ringworm of the scalp, it seems to be on a par with most other remedies usually employed; while under observation (five weeks), they improved slowly. In these five cases of trichophytina, extraction of the hairs, although advised, was inefficiently carried out. The strength of ointment used was ten to twenty per cent.

In tinea versicolor, either as a lotion or ointment, resorcin has a curative action, but it is inferior to the common remedies employed. Used side by side with hyposulphite of sodium, the latter is found to be much more rapid in its effect.

In painful leg ulcer, resorcin in some cases acts admirably. In five of the six cases recorded, pain was almost instantly allayed; and in one, a complete cure resulted. In four cases, improvement was noted, but healing only progressed to a certain point. In the sixth case, marked aggravation followed. It was employed in strength varying from eight to twelve and one-half per cent, the ointment kept constantly applied, renewing usually twice daily. In seborrhœa, and also in alopecia dependent upon this disease, good results may be, in some cases, obtained by employing an application similar to that recommended by Ihle, consisting of a drachm of resorcin, one to two drachms of castor oil, four or five minims of Peruvian balsam, and four ounces of alcohol. This should be applied every night, being well rubbed in, and the scalp shampooed every four or five days. While the result with this plan of treatment is not always positive, its action in a fair proportion of cases entitles it to favorable comment. In psoriasis, as also in sycosis, the drug seems practically valueless. In the single case of lupus erythematosus in which it was tried, there was no improvement. In one case of simple superficial epithelioma occurring on the nose it was used as a strong ointment,

forty per cent, and so far (two months after healing) the result has been good. In a second case in the same locality, and in a third case occurring about the ear, it was without effect. In a single case of favus of the scalp, in a boy of 15, resorcin was used faithfully for two months, apparently with little, if any, effect; the ointment used consisted of two drachms of resorcin and six drachms of lanolin.

Ichthyol: Employed in 8 cases of acne rosacea, 10 cases of acne vulgaris, 12 cases of eczema, 4 cases of furunculus, 3 cases of psoriasis, and 1 case each of lupus erythematosus and favus; total, 39. The cases of acne rosacea were of the ordinary type, redness being due more to simple stasis than to permanent enlargement or dilatation of the vessels. The strength of ointment used varied from five to thirty per cent. The stronger ointments proved too irritating in the majority of cases, and it was found that the strength generally suitable was ten per cent. In one of the cases, the result was good, marked improvement following within a few weeks after beginning treatment; in two cases, the result was fair; in one other, the improvement was slight; in the remaining four, no change for the better occurred, and, in fact, in two of these the disease was aggravated. In acne vulgaris, the degree of usefulness was about the same as in acne rosacea: two cases were practically relieved, three somewhat improved; in three cases, no change; and in the remaining two cases, the disease was made worse. The strength of ointment varied from five to fifty per cent; the strongest applied to lesions only. In the average case, where the application was made to the whole face, a ten-per-cent ointment was employed.

In eczema, ichthyol, as was to be expected, was found applicable only to the squamous form. In vesicular and erythematous eczema, as well as the other acute and subacute varieties, it is irritating. Even in squamous eczema it has no positive beneficial effect. It was employed in this form in the strength of one or two drachms to the ounce. In furunculus, ichthyol in the form of a stiff ointment applied as a plaster proved valuable in two of the four cases, the beginning furuncles aborting, and those that had partly and fully matured becoming less painful, and healing satisfactorily. The strength of plaster used was twenty per cent. In the third case, the application appeared to be beneficial. In the fourth case of this disease, the effect was negative. In the three cases of psoriasis in which this remedy was used, in thirty-per-cent ointment, the lesions were practically uninfluenced.

In the case of lupus erythematosus, ichthyol was prescribed in ointment form, ten and twenty per cent strength, with slight improvement, but there was no positive effect. In the single instance of favus of the scalp, the same case in which resorcin was tried, ichthyol was used as a twenty-five-per-cent ointment for a period of three months, and at the

end of that time it was difficult to say that the disease had been perceptibly improved.

Lanolin: This ointment base, consisting of about seven parts cholesterol fat and three parts water, now well known, will probably win for itself general recognition. As with all new and costly remedies, it is not always easy to procure a thoroughly reliable preparation. Although lanolin (as introduced by Liebreich) should contain about thirty per cent of water, a sample accidentally came under my notice lately with which it was impossible to incorporate the slightest additional amount of water, showing that complete saturation had been practised, or, in short, the sample apparently was made up of equal parts of cholesterol fat and water. In one instance also the specimen consisted of pure cholesterol fat, although labelled lanolin, there being an entire absence of water.

Cholesterol fat alone should, for obvious reasons, be the ointment basis (rather than the mixture with water), from which to prescribe; water or any other substance being added in the proportion circumstances might demand. This fat, as manufactured at present from sheep's wool, has the strong sheep odor, disagreeable in the extreme, but this, strange to say, is to a great extent lost when mixed with water, so that in lanolin the sheep's odor is not at first so noticeable, but when applied to the surface the heat of the body soon dissipates the water, and the disagreeable odor is developed. This odor is the main disadvantage of lanolin as an ointment base. Another disadvantage is its consistence, which may be obviated, however, by the addition of twenty to thirty per cent of an ordinary fat. Within the past month Liebreich, in a note in the *British Medical Journal*, calls attention to an improved lanolin—lanolinum purissimum—in which the cholesterol ethers are entirely absent, and the consistence such that no addition of other fat is necessary.

It is now, I think, by various authorities proven beyond doubt that lanolin is more rapidly taken up by the skin than any other fat. This property is susceptible of clinical proof, and in this, therapeutically, is its great advantage. In acute inflammations where merely a protective influence is the object, this property is undesirable, and in such cases, if ointments are used, cold cream, vaseline, or a mixture of vaseline and lard is preferred. On the other hand, in cases of chronic eczema, psoriasis, and similar diseases, where there is thickening or infiltration, and a degree of penetration is desired, then lanolin is superior to the ordinary fats. In a few cases of an acute and subacute type the application of lanolin proved, for some reason, irritating.

In sycosis and the parasitic diseases, lanolin was also used as the ointment base, and although, theoretically, it should be vastly superior, my experience so far has failed to prove any marked advantage in these cases over simple lard.

NOTES OF A CASE OF EXFOLIATIVE DERMATITIS (PITYRIASIS RUBRA?), WITH BULLOUS LESIONS.¹

BY

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I HAD hoped to present the notes of a number of cases under the general title of "exfoliative dermatitis," *e. g.*, illustrations of classical pityriasis rubra, pemphigus foliaceus, together with intermediate forms of disease belonging to this family group, but circumstances have compelled me to surrender my design for the present, and to ask your attention to a very brief and somewhat imperfect account of the following unusual case:

On Feb. 21 of this year, I was asked to see a lady who was suffering from a very annoying and extensive disease of the skin.

The patient, who was confined to bed, was of about forty-five years of age, very stout, and somewhat nervous. I found that she had always been an exceptionally healthy person, and indeed, barring a slight facial neuralgia, had never been seriously sick at all. She had never suffered from a skin disease of any description before.

The present affection dates from on or about the 1st of February, and followed upon attendance on an evening entertainment, where she was much fatigued. Coming home late at night, she felt thoroughly chilled in the carriage, and went to bed feeling ill. The next day she noticed that there was a red patch at the pit of the stomach, which itched a little, and spread rapidly, the different red places that afterwards developed soon running together and leaving no healthy skin between. There was no great amount of scaling at first, but some degree of pruritus. She positively declares that there was no moisture.

When I first saw the patient, the disease had been in progress perhaps for twenty-one or twenty-two days. The chest, abdomen, arms, back, and thighs presented the usual appearances of pityriasis rubra. There was neither moisture, crusts, nor appreciable infiltration, but the skin was shining and of a marked violaceous hue. She complained at this time of great burning and tension of the integument; the sensation of itching had seemingly subsided. She was very nervous, and altogether wretched.

In the mornings, a handful of scales could be gathered from the sheets, but they were not so large as is usual, and were inclined to be

¹ Read at Tenth Annual Meeting of American Dermatological Association.

furfuraceous. Still the desquamation was a marked feature of the attack. The face was not involved, and on the legs below the knee there were at this time some uninvaded regions.

Three or four days after I had first seen the patient, and about twenty-four days from the beginning of her disease, there appeared on the thighs, abdomen, and buttocks, where the skin was highly inflamed, a number of tense bullæ, varying in size from a finger-nail to a silver twenty-five-cent piece.

This new manifestation was preceded by a distinct chill, just as I have observed in pemphigus foliaceus, and was followed by a moderate elevation of temperature. The blisters did not run into each other, but kept their individual characters until punctured by the patient, which she did on account of the pain and discomfort produced by them. Their contents were clear. I presume that there were never more than a dozen bullæ out at one time, but each crop was preceded by a chill. There was no regularity, so far as I could make out about this symptom, as to the time of day of its occurrence; but some time in the morning or some time in the afternoon the patient would observe that a crop of bullæ had supervened upon a chill. The bullæ were not grouped, but scattered irregularly over the surface.

I gave the patient freely of quinine, and at the end of a week the bullæ had ceased to appear, but, of course, I cannot say whether they would not have disappeared just as well without the quinine.

The floors of the bullæ differed little in appearance from the surrounding inflamed skin, being perhaps a little redder and somewhat more moist at first. When the roofs of the blisters were hanging in shreds on the reddened skin, there was a certain resemblance at these points to pemphigus foliaceus.

At this period in the case I was obliged to discontinue my visits, and what was the further history I am unable to state definitely, but I believe that the patient gradually improved.

My assistant, Dr. Eversole, saw Mrs. X. some time later, after the bullous stage had passed away, and he told me that the affection presented the usual features of pityriasis rubra. I wrote the patient recently for further notes of her case, but I have as yet received no reply, as she had left town for the summer.

So far as I know, the only other case bearing much resemblance to the one I have recorded above has been recently reported by Dr. P. A. Morrow (*JOURN. CUTAN. AND VEN. DIS.*, June, 1886), in which a well-marked case of pityriasis rubra presented numerous pin-head-sized vesico-pustules as a complication.¹ I shall refrain from making any es-

¹ Weyl (*Ziemssen's Handb. der Hautkrankh.*) says that in dermatitis exfoliativa acuta a few feeble vesicles may appear.

pecial comment on this case until I shall have an opportunity to publish the whole series, of which this forms a part.

However, so much may be said at least, that certain forms of disease, which have generally been regarded as running a dry course, may be complicated under certain circumstances by lesions containing fluid.

A CONTRIBUTION TO THE CLINICAL STUDY OF SCLERODERMA.¹

BY

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SCLERODERMA is a somewhat rare and obscure disease which, notwithstanding its well-marked clinical characters, still baffles all efforts made to ascertain its true pathology. The following histories of two cases are simply given as additional examples of the disease. They do not present many points different from those already described, yet every case has some peculiarities of its own which may, along with others, help to make up a true clinical picture of the disease.

The first case occurred in the practice of Dr. Smith, of Seaforth, Ontario, to whom I am indebted for the notes, given in his own words, in this paper. The history is as follows:

Mrs. R., age 47, came under my notice in August, 1882, while visiting relatives in Canada. Her home was in the northern part of Michigan. The family history was good, and the only severe illness she ever had was eight years previously, when she suffered from acute rheumatism.

About seven months previous to coming under my notice, she had a severe chill after a hard day's work, and a day or two later she observed that a small portion of the skin on the back of the neck felt hard, and this soon spread over the neck until turning the head from side to side became quite difficult. She felt as if something were tied tightly around the neck. During the next two weeks the disease gradually spread until nearly the whole integument of the body became indurated. When I first saw the patient, she told me that she felt as if the whole body was wrapt in thin, hard leather. She walked and moved her arms with considerable difficulty, and she evidently suffered no little inconvenience from the "tightening" of which she complained. The fingers and toes were slightly bent and deformed. The respirations were more or less interfered with, and the appearance of the mouth and eyes was most peculiar. The temperature was normal and the degree of sensibility was but slightly impaired. She had consulted several physicians, but she had

¹ Read at the 10th annual meeting of the American Dermatological Association.

never put herself under any thorough course of treatment. I prescribed for her Syr. Ferri Iodidi and Liq. Arsenicalis, the latter in five-minim doses after each meal. As a local stimulant, I recommended the use of electricity, and directed her to procure a battery and to persevere in its use daily.

I had some difficulty in getting her to consent to follow out the above treatment faithfully, owing to the fact that she had already become discouraged. She returned to her home in Michigan and informed me, six weeks after her return, that the skin was becoming somewhat softer to the touch, and that she could walk and use her arms with much more freedom. I advised the continued use of the remedies prescribed, and wrote to her to be particularly careful to use the battery as directed, rubbing the body and limbs carefully with the sponges, as I had shown her.

At the end of three months, I was glad to receive the report that she was almost entirely free from the disease. She has since enjoyed fair health, but has had no return of the scleroderma.

In this case, there was no œdema at any time. There was slight pigmentation at the back of the neck and over the upper lip. Dr. Smith did not inquire if rheumatism existed in the family, but is inclined to think that there is a hereditary tendency to that disease.

The second case, sent by Dr. Jenner, came under my observation last May, when the following notes were taken:

Mr. H. æt. 39; married; occupation, carriage-builder. Family history shows evidences of hereditary rheumatism. His father, who died aged 77, suffered for many years from rheumatism, which rendered him unable to walk without crutches. One brother had rheumatism for some years and died of Bright's disease. There is no other history of hereditary disease. The patient himself enjoyed good health previous to the commencement of present disease. He has never suffered from any serious disease or injury. He used tobacco up to ten months ago, when he gave up this habit. He has been a hard-working man, standing always at the bench.

About seven months ago, he first noticed stiffness of the limbs, as though he had caught cold. When at work, the stiffness would leave him, but would return at night when he remained quiet. At the same time, he had swelling of the legs. So far as could be ascertained, the swelling was due to œdema. This continued for six weeks, during which time he bandaged the legs. About the middle of December, *i. e.*, four weeks after the commencement of the œdema, he noticed a discoloration of the hips and groins, which he thinks came on quite suddenly. In about the middle of March, his brother noticed that the skin over the hips and thighs was hardened. It is probable that the induration began some

weeks previously, but was not noticed. This hardened condition spread quite rapidly, until the integument over the trunk and limbs became more or less affected. For the last two months, there has been no change in the extent or amount of the induration. He has lost weight. He has suffered much from constipation. The urine has not been increased in quantity, but at the commencement of the illness he had to pass water much more frequently than normal.

Present condition: Patient is tall and thin; weight at present one hundred and sixty-five pounds. He has a dark complexion and blue eyes. He cannot remove his coat without assistance, on account of stiffness of the arms. The skin of the chest is tightly drawn over the ribs, so that there is very little expansion of the chest, even on deep inspiration. The integument is not thickened in this region, and the tension is much greater anteriorly than posteriorly. It was found also that the skin was much tighter when the patient was standing than when sitting. There was no discoloration over the chest.

Abdomen.—Anteriorly, the skin is tense, somewhat thickened, and the lower part is discolored. Over the right and left inguinal regions the pigmentation is most marked, the integument being as dark as that of a mulatto. Cannot pinch up the skin over the front of the abdomen. Posteriorly, over the lumbar and sacral regions the skin is extremely tense, indurated, and very deeply pigmented, and presents a shining appearance. Over the gluteal region there is also tension and induration, but neither of these conditions is as marked as over the parts higher up.

Thighs.—Over the hip-joints the disease exists to its greatest extent. The parts are as hard as wood, and the integument is firmly attached to the parts beneath. The discoloration also exists here in its greatest intensity. Over the lower part of the thigh the disease exists in a uniform and milder form. The condition is intensified when he stands up. He is more inconvenienced by the stiffness in the popliteal region, as it affects his getting up and maintaining the erect posture.

Legs.—The discoloration is greater over the legs than over the thighs. Anteriorly, there are some white spots, showing complete absence of pigmentation. Here the skin presents more of a cicatricial appearance than over other parts of the body. The calves are atrophied, and the skin over them very tense. On the other side of the right leg the brown pigmentation is interrupted by white lines, which cross one another so as to give it the appearance of a checker board. Patient states that, where there is now absence of pigment, there was at one time deep pigmentation. The skin of the feet is also tense, and the discoloration gradually diminishes to that over the toes, where the condition is about normal. There is some stiffness of ankle-joints.

He sleeps well and suffers no pain whatever. Patellar tendon reflex absent. No ataxic symptom in either upper or lower extremities.

His heart and lungs are healthy. Appetite good. Pulse ninety. Temperature normal. Respiration twenty-three. The frequency of respiration and pulse is probably owing to the difficulty of expansion of the chest. He complains of a feeling of tightness after eating a full meal. His eyesight and hearing are good. He has never suffered from mental worry or shock.

He walks with some difficulty, but can go a long distance. His steps are short, and he experiences great difficulty in arising from a chair. The impediment in moving is due entirely to the condition of the skin. The face and neck are not affected. There is diminished sensibility over some of the sclerosed parts, while over others the sensation is normal.

This patient was put on potass. iodid., syr. ferri iodid., and cod-liver oil. The constant current was applied centrally and locally. Friction of the parts with olive oil was also recommended.

The patient remained under my care for about three weeks, and then went home. Dr. Jenner has written me lately that the condition is somewhat improved.

He has for the last few weeks taken salicylate of soda, without any good result so far.

It is not the intention of the writer to more than merely discuss some points which appeared to him of interest in connection with this obscure affection. In the first place, as to the frequency of the disease, Dr. Van Harlingen, in his exhaustive article published in 1873, gives twenty-eight cases which he had collected from various sources, twenty of whom were females and eight males. From a brief survey of the literature from 1873 to the present, I found about thirty cases. Dr. Crocker, who includes morphœa with scleroderma, places the number of recorded cases at 120.

Like other rare affections recently described, it will be found that cases are more numerous than at first supposed. It is probable that the disease occurs more often in temperate climates, where there are frequent and sudden changes of temperature. In the writer's limited field of observation, three cases of scleroderma and one of morphœa have occurred during the past ten years. It will be found that, of the recorded cases, only two or three are reported from warm climates, and that the great majority have occurred in the temperate region of Europe and America.

It is quite improbable that such a general condition as scleroderma can be a purely local disease. There are doubtless pathological conditions existing in the deeper organs which have so far escaped observation. Two classes of diseases suggest themselves as likely to be more or less connected with this condition, viz., the tropho-neuroses, and secondly, the

various forms of rheumatism. It has been the generally accepted opinion that scleroderma is a tropho-neurosis, and that the true cause exists in the trophic nerve centres. One great difference, however, exists between some trophic diseases, such as prog. musc. atrophy, pseudo-hypertroph. musc. paralysis, and that under consideration, viz., that in the former the lesion, in most cases, is either permanent or progressive in character, whereas in scleroderma, in many cases, recovery takes place sooner or later.

In my opinion, the disease is more nearly allied to the rheumatic affections. By this I do not mean to deny that there is also a close relationship with the tropho-neuroses, for I regard many rheumatic joint affections as of a neurotic origin. It has been clearly shown that the arthropathies which Charcot has described in connection with locomotor ataxia are of nervous origin, and Dr. Ord, in his address on medicine before the British Medical Association, in 1884, also demonstrated the intimate relationship which exists between certain rheumatic affections, such as rheumatoid arthritis and trophic nerve lesions.

Now, as to the connection of the disease with rheumatism, Dr. Duh-ring states that "rheumatism, especially of the joints, has been noted to precede the attack in many cases."

In the clinical lectures delivered by Dr. Crocker last year, the following opinion is given:

"What is, then, the relation of acute rheumatism to scleroderma? Is it etiological? I scarcely think so. While there are on the one hand only a moderate proportion of scleroderma patients in whom the two diseases are associated, there are many scleroderma cases in which there has been no antecedent or associated rheumatic fever, while scleroderma would not be so rare if so common a disease as rheumatic fever was of direct etiological importance. I regard them, and also ordinary articular rheumatism which frequently accompanies scleroderma, as being due to a common cause, viz., exposure to cold, which is one of the most frequent and important causes of scleroderma."

It must be remembered that there are a great variety of affections classified under the head of rheumatism and rheumatoid arthritis.

Any one who studies the subject of rheumatism, particularly that of a hereditary character, will be surprised to learn of the infinite variety of its manifestations. It may occur in some as an arthritic affection, in others the muscles and tendons are attacked, while in others again the principal difficulty is an abnormal state of the digestive and assimilative functions. It has recently been shown that, in this way, an intimate relationship exists between rheumatism and some forms of diabetes, and that anti-rheumatic remedies, such as salicylate of soda, will act favorably on these cases of diabetes.

Taking this view, it is not so difficult to suppose that scleroderma may be one of these varied manifestations. It is not necessary, therefore, to show that a majority of scleroderma patients have also had rheumatism, but it would be of interest to know in how many cases a predisposition to rheumatism, or what may be called a rheumatic diathesis, existed.

In studying the changes which take place in joints in chronic rheumatic affection, we find that they are often very similar to those which take place in the skin in scleroderma.

Thus you have first an increase of connective tissue which, in many cases, is followed by atrophy in the same way that we have hypertrophy of connective tissue in scleroderma followed by atrophy. In the chronic nature of the process, these two conditions resemble one another.

Morphœa, too, in some instances at least, seems closely allied to rheumatism, as is shown in the case related by Dr. Dyce Duckworth.

Again, in quite a number of cases of scleroderma, pericarditis is met with—a condition so often met with in rheumatism.

The frequency of rheumatism, and the rarity of scleroderma, is not an argument against the relationship of the two diseases. The rheumatic form of diabetes is also a comparatively rare disease, and still the relationship has been clearly shown.

On going over the whole subject, I think there is sufficient ground for treating cases of scleroderma with anti-rheumatic remedies. We find that those means, such as friction with oil, Turkish baths, potass. iodid., have been found useful. Salicylate of soda has been used in two or three cases, but I do not know if salicin and other alkaline preparations have been tried in this disease.

Now, as to the much disputed point of the relationship of this disease with morphœa, it is probable that etiologically they are closely connected, and certainly cases have been described in which the two conditions are so closely combined that it is impossible to draw a dividing line between them. It may, however, be of advantage to consider them as two separate diseases until our knowledge of the two affections is more extensive and more accurate.

With regard to the chronicity of the scleroderma, I am of opinion that Dr. Duhring is correct in considering that we have an acute and chronic form of the disease. The first case given in this paper would belong to the acute, and the second to the chronic variety.

So far as I could learn, the acute is the rarer form. Only four or five cases have been published: one by Crocker, one by Piffard, two spoken of by Dr. Duhring, and two reported by myself. In the acute form, there is, I think, less pigmentation.

The two cases which I have known of, both were in women, and in both there was little or no pigmentation. There is also less atrophy.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

165TH REGULAR MEETING.

DR. ROBERT W. TAYLOR, *President, in the Chair.*

DR. DANIEL LEWIS presented a

CASE OF EPITHELIOMA OF THE FACE,

with the following remarks.

The patient was a man 53 years old. The disease began seventeen years ago, was first considered an eczema, was treated with benzoated zinc ointment, and arsenic internally, but instead of improving grew steadily worse. Then his physician, a very reliable practitioner of Sacramento, Cal., from whose letter this history is obtained, concluded the ulcer might be of a specific character, and treated him accordingly, but to no purpose. He then referred him to a dermatologist of San Francisco, who pronounced it a case of rupia, but after fifteen months' treatment totally failed to benefit the patient. The progress of the disease has been constant. Another physician endeavored to cure it by a thorough application of Vienna paste. Professional cancer curers have also had him in charge of late years. He reached my office a few days since with a dressing of "Cuticura Soap."

The disease began first as a slightly elevated patch about the centre of the right cheek, upon which a thin crust would form, and in a few weeks be detached by shaving and then reproduced—the usual history of flat epithelioma of the face. As far as I can learn, all ulceration has spread from this single point.

At present it involves a nearly quadrangular space extending from above the right ear to near the outer angle of the eye, downward to the inferior maxilla, backward to the inferior mastoid region. Most of the external ear has been destroyed, the surface of the ulcer being twenty-five square inches. In some portions, the disease does not extend much beyond the depth of the true skin; in others (as in the portion below the malar bone), it is a question whether it has not actually invaded the mouth. The posterior and inferior borders are indurated, elevated, and everted for some distance. The surface is not secreting copiously, nor are the secretions especially offensive. There are no enlarged cervical glands. There is no family history of cancer. He had a venereal sore thirty years ago, and a suppurating bubo. I cannot satisfy myself that he ever had syphilis, in fact believe he had not. His general health is impaired, chiefly as a result of peritonitis, three years ago, and considerable effusion, for which he was tapped several times. He now has a much enlarged spleen. I should like to have my diagnoses of epithelioma, *ab initio*, reviewed, and receive suggestions from the members of this Society in regard to treatment.

If it is deemed advisable to undertake *any* treatment, the plan I have to propose is this: to make an incision entirely around this ulcer and with the knife, secure as broad a border as possible which is healthy, and then treat the balance

of the surface by the Paquelin cautery. Unless some intercurrent trouble, disconnected with this disease, steps in to hinder this proceeding, I believe recovery possible.

In the discussion which followed, DR. JACKSON agreed with the diagnosis, but as regarded prognosis and treatment he differed from Dr. Lewis, believing that the operation proposed did not offer any chances of a permanent good result.

DR. SHERWELL said he would fear to operate, and considered euthanasia under suitable doses of opium the most desirable thing under the circumstances. The case was interesting to him as bearing out a previously expressed opinion, that many of these epitheliomata have their starting point in a mole upon the face, which has in some way become irritated. He had learned from the patient that he had cut off the top of a mole while shaving, and this appeared to be the point from which the disease took its origin.

DR. FOX said he should endeavor to prevent the further spread of the disease by occasional operation, and a radical operation might be attempted. He would scrape and cauterize the base which would improve the condition, even if it had no decided effect on the prognosis.

DR. BRONSON advised curetting a zone near the periphery, having the actual cautery at hand in case of hemorrhage from any large vessels. He thought that at many points ground might be saved.

DR. BULKLEY had seen two similar cases. In one, an attempt had been made to remove the disease by a radical operation, but a recurrence of the cancer soon resulted in death. In the second case, no radical operation was attempted. He would treat such a surface as here presented, with a corrosive sublimate solution 1:5,000, applying iodoform at times in combination with tannin and powdered starch. After a thorough excision of a portion of the disease, at the margin, he would like to see the bodily transplantation of a large piece of skin from the patient's abdomen. He had witnessed a perfect result from a large transplantation for ectropion resulting from syphilitic scarring.

DR. TAYLOR agreed with Dr. Bulkley as to the inadvisability of operation.

DR. SHERWELL had seen inflammatory reaction follow the use of iodoform, at the same time that a bichloride solution is being used, and for his part would not use the two drugs at the same time. Dr. Bulkley and Dr. Piffard had used iodoform after bichloride solutions many times, and had never seen any ulterior results.

In closing the discussion, DR. LEWIS said that the superficial nature of the ulcer, and the fact that the disease had progressed so slowly, made him believe that the procedure he proposed was justifiable. He did not believe it proper to leave such cases without treatment, not only on account of the bad moral effect of refusing to operate, but also because much benefit might result. He had thought of making the incision in the healthy skin about the ulcer, to insure better granulations than would start from a scraped surface. Dr. Piffard did not admit this proposition, believing that scars after curetting are usually good, the granulations prompt, and not so prone to form hypergranulation as after incision.

DR. BULKLEY presented

A CASE OF LICHEN PLANUS

of somewhat unusual form, of which the following is the history:

Mary Doyle, unmarried, aged 29, seamstress, presented herself at my clinic at the New York Hospital October 31, 1885, for the treatment of an eruption which presented and still presents some peculiar features.

The first lesions appeared upon the legs four years previous to her visit; and very shortly after, upon the forearms. Upon these places they have remained to the present time, in spite of considerable treatment and a pretty faithful attendance at the hospital for ten months. The patch at the nape of the neck came somewhat later. From the beginning of the eruption, itching has been a most marked feature, causing at times very great distress, as is evidenced also by the very extensive and in places deep marks of scratching.

When first seen, the eruption presented very much the condition seen at present, although during the period she has been under observation the lesions have changed their condition, many have disappeared, and new ones have formed. Some of these have at times exhibited very clearly the characteristic and typical flat summits, with somewhat of a depression, have been of a violaceous color, and have either vanished or developed into the larger brownish and purple lesions now exhibited.

At present the eruption is confined to the extensor surface of the lower legs and forearms, and covers a patch about an inch and a half in diameter, of irregular shape at the lower border of the scalp, in the median line behind. No other parts have ever been invaded. On the legs, the eruption consists of brownish and purplish lesions, varying in size from one-quarter to three-quarters of an inch in diameter, of irregular shape, scattered among brownish stains of former patches, and torn remains of others. Some of them are very perceptibly elevated, and rough and almost horny on the surface. On the forearms, the lesions are fewer and smaller, with occasional papules typical of the disease, and scratched papules and stains. On the nucha, the patch is made up of more closely set lesions, forming a quite even patch, much resembling the ordinary eczema seen in this location.

The treatment has been varied, but never with any very marked and permanent benefit, although improvement for a while has followed a variety of measures. Arsenic has never been well tolerated and has not proved of service. Locally, the liquor picis alkalinus has given the most relief.

The interesting features of the case are the peculiar localization of the eruption, the brown, hard character of the lesions on the lower extremities, and its rebelliousness to treatment.

DR. BRONSON regarded the case as one of the hypertrophic forms of lichen planus, and suggested as local treatment strong application of carbolic acid.

DR. BRONSON presented

A CASE OF DERMATITIS HERPETIFORMIS.

The patient was a man 32 years of age, of fairly robust appearance, and with a history of good average health. Seven years before, he had had an initial lesion followed by adenopathies and some alopecia during the first year, but had had no symptoms since. Present eruption began about five years ago in the spring, and had continued almost without intermission until now. When first noticed, its efflorescences were papular and seemed to affect the sites of the hair-follicles, always occurred in groups, and were attended with itching. Latterly they have been vesicular. At present the groups are scattered over the greater part of the body and extremities, and vary in size from one and one-half inch to two or three inches in diameter. They are composed of small papules (often eroded) and vesicles, some miliary and some larger in size. Occasionally, bullæ are produced as large as the little finger nail. The vesicles are usually tense and clear. In certain places, as on the thighs and buttocks, the groups are distinctly annular. In other situations, there will be merely a cluster of from three to five efflorescences. The majority of the lesions consist of a papule surmounted either by a bloody crust or a vesicle so fine as to be visible only when the part is pinched up between the thumb and finger. Many (if not all) of the lesions appear to proceed from hair-follicles. They are distributed alike over the trunk and extremities; less frequently on the face, and never on hands or feet. Has heretofore obtained marked relief from Fowler's solution of arsenic.

In discussing Dr. Bronson's case, Dr. SHERWELL spoke of two cases of this disease which he had observed, in which he was led to examine the urine for sugar and found it present in both cases. He asked if this patient's urine had been examined. It was stated that it had been and was found free from sugar.

Dr. BULKLEY, in protesting against the name *dermatitis herpetiformis* being given to a great variety of affections presenting polymorphous lesions, nevertheless looked upon this case as one which could properly be so designated, on account of the herpetic element being marked.

He reported, in regard to the case of *dermatitis herpetiformis* presented at the January meeting, that the young man had fully recovered under full doses of arsenic in the form of arseniate of soda given up to the point of toleration, taking as much as ten or fifteen drops or more of the solution three times daily. He had found it better, in some cases, to give the drug on an empty stomach, either alone or in Vichy water.

In closing the discussion, Dr. BRONSON said that, if the name *dermatitis herpetiformis* was ever justified, it surely was in this case, because of the tendency to herpetic groupings and forms manifested, and on account of the vesicular character of the early lesion. His patient had found great relief from the use of arsenic, especially in controlling the itching and burning, but was forced to abandon its use on account of its constitutional effect. He had been able to use Dr. Keyes' prescription of arsenic, *nux vomica*, and pepsin without any bad effect upon the stomach.

Dr. TAYLOR presented a case of

URTICARIAL ERUPTION DUE TO IODIDE OF POTASSIUM,

with the following history, read by his house surgeon, Dr. J. A. Bosch.

The patient, Mary Johnson, aged 26, single, German, domestic. Ten years ago, she had vaginitis; eight to nine years ago, she had buboes in both groins. Three months after this, she contracted a sore on her privates, which was followed by an eruption, sore throat, and falling of the hair. Three years afterward, she states, ulcers broke out on her legs. She was treated with iodide of potassium, and soon developed an iodide eruption, similar in character, she thinks, to the present. One year ago, she entered Charity Hospital with an ecthymatous syphilide. She was put on treatment, and left the hospital much improved. She re-entered the hospital September 23d, complaining of her old symptoms, and was put on gr. xv. doses of the iodide, t. i. d. After the fourth or fifth dose, she developed an eruption of the urticaria type, with well-marked symptoms of iodism. The iodide was stopped, and the eruption has changed somewhat in character.

The eruption appeared within twenty-four hours after the first fifteen-grain dose of the drug, and showed all of the characteristics of an urticaria, occupying and being confined to the backs of the hands and wrists, and the face and neck. Many of the wheals were surmounted on the second day of the eruption by a pellucid vesicle.

Dr. Taylor believes that urticarial eruptions, due to the ingestion of the iodide, are not at all common, and thinks this case of especial interest at this time, when so much attention is being paid to iodide eruptions, from its rarity, the region occupied, and the fact that this is the second time he has observed the patient to be thus affected by the drug.

In the discussion which followed, Dr. MORROW regretted that the urticarial wheals described by Dr. Taylor had in a great measure disappeared, leaving appearances which could with difficulty be differentiated from the syphilitic lesions present. He would not expect a syphilitic eruption to terminate so abruptly upon the backs of the wrists as in the case presented. Although he personally had never seen a case of urticarial eruption due to iodide of potash, many cases of this eruptive form had been recorded, and he had no doubt Dr. Taylor was correct in

the present diagnosis. In this eruption the larger papules are surrounded by an areola, and differ from ordinary urticarial papules by their higher coloration.

DR. FOX related the case of a woman with syphilis he had treated some time ago, who had repeated outbreaks of vesico-pustules. He had suspected the iodide she was taking as being the cause of the eruption, and suspended its use, but the eruption appeared when she was not taking it, and did not appear at times when she resumed it again. By tests of this nature he was enabled to conclude that the iodide was *not* at fault.

DR. LEWIS said he had never seen urticaria from the use of iodide of potassium, but as he was not in the habit of giving large doses, excepting in cases of syphilis of the brain, it might be on that account that he had not observed it.

DR. BRONSON never saw an urticaria due to iodide, and was inclined to think that the eruption was not due to an idiosyncrasy for iodide of potassium, as much as to a general drug idiosyncrasy. Urticaria may be produced by any substance taken into the stomach which will produce reflex irritation.

DR. MORROW asked if Dr. Bronson meant by a general drug idiosyncrasy that the intolerance of iodide of potassium exhibited by this patient would also be manifest against quinine, arsenic, and other drugs.

DR. BRONSON said he meant that, under certain conditions, a great variety of things will cause an urticaria, among them certain drugs, and that he knew of no reason why iodide of potassium might not also do so.

DR. BULKLEY called attention to the appearance on the patient's hand, where in fading away the urticarial wheal had left a halo surrounding a central papule. This solid element being left behind was a feature of urticaria which he had previously noticed.

In closing the discussion, DR. TAYLOR said the connection between the eruption and the ingestion of the drug was undoubted, since all other factors had been eliminated. This fading of the urticarial appearance of the eruption, leaving papules behind, as spoken of by Dr. Bulkley, presents a condition which would at the present time be called a papular erythema following iodide of potassium.

DR. TAYLOR then presented a boy having upon the penis an anomalous lesion which had been described by Dr. Morrow under the name of

"DIPHThEROID CHANCRe."

The patient, aged 16, entered Charity Hospital, September 10th, 1886. His history was rather unsatisfactory. About twelve weeks prior to admission, he noticed a small pimple situated on the glans penis, which he states appeared from two to three weeks after intercourse. He was careless about his toilet and allowed the subpreputial secretions to accumulate under the prepuce. A few days later, the pimple increased to about the size of a quarter dollar, extending on to the balano-preputial fold, and was covered by a glistening grayish-white membrane, resembling a diphtheritic exudation.

This membrane was intimately adherent, slightly elevated, and had a peculiar leathery consistence. The edges were somewhat raised and surrounded by a well-marked line of demarcation between its border and the tissues around it. The membrane was of a uniform thickness, and not surrounded by an area of inflammation. In was not painful on manipulation, appeared sluggish, and had a smooth, semi-cartilaginous, greasy feel. On examination of the tonsils, a similar condition was observed. Between his nates and surrounding the anus were about a dozen condylomata, extending anteriorly to the margin of the scrotum. These were irregular in outline, fairly well developed, and in some places had coalesced and presented a cauliflower appearance.

The glands in the groin, the cervical and epitrochlear glands were all enlarged.

He states that he noticed no roseola, nor alopecia; but the former condition may have existed and escaped his observation, owing to his careless habits. He

lived in the poorer quarters of the city with his family, all occupying but two rooms; washing themselves in the same basin and using the same towels.

When we come to the family history, we find that the boy's mother has been suffering from a sore situated on the corner of the mouth. This was indurated, and had no tendency to ulcerate. Her body was covered with a papular eruption which had been preceded by a roseola. She had in addition general glandular enlargement.

The boy's sister, aged 12, with whom he had been in the habit of sleeping, presented at lower vaginal commissure a small sore, bearing the same characteristics as the mother's. She had some oedema of the face, a slight conjunctivitis, and a circumscribed blush around the eyes. The inguinal and cervical glands were enlarged. A nephew of the boy, 9 months old, who slept in the same room, had a sore on either side of anus, about size of a half-dollar, which extended to nates. It was excavated, had a slough in centre, the borders were firm and hard, and it was attended with an ichorous discharge. There was also a sore on side of scrotum, and another on inner side of thigh, both about as large as a five-cent piece. They were painful to the touch. The glands in cervical and inguinal regions were markedly enlarged.

The throat was congested, and the child had emaciated rapidly since the appearance of these sores.

There was still a brother, aged 5 years, who had a suspicious-looking fissure on the corner of the mouth; it was of a grayish color, indurated, and not attended by any discharge. This boy had no constitutional symptoms, but the lymphatics were all enlarged. A married sister (mother of the baby), who slept in the same room with her husband and child, had had syphilis, but her symptoms disappeared under treatment.

DR. MORROW said this was a very rare form of initial lesion. He had seen a case with Dr. Bronson, a number of years ago, of which this was a good counterpart, except that the lesion in this case occupied a smaller surface, and the more characteristic features were less developed.

The peculiar grayish-white appearance of the patch was here not so pronounced, and the layer not so thick. The location of the lesion, the unbroken character of the layer, its raised, well-defined border, the existence of condylomata about the anus and scrotum, and the almost complete absence of other specific symptoms made the two cases strikingly similar.

DR. BRONSON agreed with Dr. Morrow that this was a counterpart of his case in the period of decline, when it had lost its glistening appearance, and taken on a sodden look. He regarded the circumstance of the boy's elongated prepuce as an etiological feature; the lengthy prepuce preventing abrasion or erosion, the epidermis remains intact and the whole process goes on underneath.

DR. TAYLOR had seen Dr. Bronson's case, and several others, and had written a paper on the subject for one of the early numbers of the *Archives of Dermatology*. He described the sensation the patch gave to the finger as a leathery feel, or like wet chamois skin between the fingers. The reason this patch of gray tissue had lost its characteristic shiny appearance was because it had been energetically treated, as had also the condylomata which had been much more luxuriant and so high that they would pass for simple warts or vegetations, or acuminated condylomata. They had been treated locally with calomel, salicylic acid, and Labarraque's solution.

DR. BULKLEY related a case he had recently seen, in which an

EPITHELIOMA

had formed upon the left side of the lower lip of a man who had had a similar growth removed from the right side six years before. The scar from the previous operation was perfect, and the new lesion entirely separate from it.

DR. PIFFARD asked if it was not the patient upon whom he had operated six years ago. Dr. Bulkley said it was. Dr. Piffard had also recently seen the case, and agreed with Dr. Bulkley that there was sound, healthy tissue between the scar of the right side and the recent epithelioma of the left. The patient had told him that he had been smoking on the well side after the original operation. Previous to the first cancer, he had smoked on the right side. Dr. Piffard believed that operation was the only advisable treatment.

DR. SHERWOOD reported a case of

PITYRIASIS RUBRA

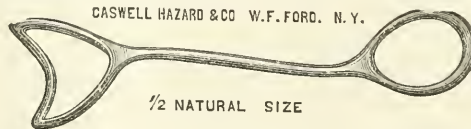
in a lady of about fifty years of age, who had been well until a little over a year ago, when the disease first appeared. He treated her, as was his custom, with inunctions of or rather soakings in linseed oil, and she recovered, and remained well for a year, until five days ago, when she again came under his care, and is being treated as before.

DR. BULKLEY reported that his two cases of pityriasis rubra, which had been unsuccessfully treated with the oil externally and internally, remained in about the same pitiable condition as at last reported. No treatment tried had done them any good. The woman of forty had been in the hospital for two years, and the ulcerations of the hands and feet were extremely painful.

DR. TAYLOR presented for inspection

AN ORAL SPECULUM,

being a modification of the very useful instrument of Dr. Piffard. The following cut gives an accurate idea of the speculum, which is well adapted to examinations



of the mouth and lips. The instrument shown was made of aluminum bronze, which seems especially adapted to such use by reason of its hardness, the durability of its lustre, and its resistance to acids and chemicals in general.

Correspondence.

MOLLUSCUM CONTAGIOSUM.

To the Editor of the Journal of Cutaneous and Venereal Diseases.

SIR:—In your issue of August appeared an article from the pen of my colleague, Dr. Charles W. Allen, upon the subject of molluscum contagiosum.

My object in communicating with you at present is not to discuss the *pro* or *con.* of the contagiousness of this affection, but merely to describe two cases of it which came under my notice, and permit them to speak for themselves.

A year ago, I was consulted for an eruption which had appeared upon the left side of a boy's face. He was five years old. This eruption presented in the form of small tumors, globular, of a glistening white aspect, surmounted by a small black spot, each tumor about the size of a pea. They were located on the lateral

surface of the nose, the lower eyelid, and the cheek, and were four in number. These growths were treated by piercing them with the nitrate-silver crayon, and disappeared. Two weeks later, the patient reappeared with several more new ones. At the same *séance*, his sister, ten years old, was similarly treated for two little tumors similar to those upon the brother. Both of these cases showed evidences of great care as to bodily cleanliness, were well nourished, and healthy.

ETIENNE C. VIDAL, M.D.

NEW YORK, September 1, 1886.

TREATMENT OF RHUS POISONING.

To the Editor of the Journal of Cutaneous and Venereal Diseases.

SIR:—I presume you may be acquainted with the fact that the green vegetable, *Atropa belladonna* (night shade), bruised and mixed with fresh cream, cures the rhus poison by being applied externally over the eruption, in from three to seven days, without other medication. I have seen the whole face and head enveloped in such a poultice with no bad effect, and perfect cure result in five days. The application is freshly made daily until cure results. Respectfully,

T. J. REID, M.D.

CHICAGO, ILL.

THE USE OF ARSENIC IN SKIN DISEASES.

To the Editor of the Journal of Cutaneous and Venereal Diseases.

SIR:—Having read Dr. Fox's article on arsenic in skin diseases in the June number of the CUTANEOUS AND VENEREAL JOURNAL, and noted your article on Arsenical Eruptions, and the request for professional opinions in regard to the use of arsenic in skin diseases, in the July number of the same journal, I have watched for, and read with much interest, the several articles that have appeared in answer to the request, but have been disappointed that more have not responded, and that so little credit has been given this drug that, in my opinion and the opinion of many well skilled in the treatment of skin diseases, is of so much value. I have waited thus long, hoping that others would give their experience and call attention to some points that I think of vast importance.

As this has not been done, I shall venture a few remarks in reference to this remedy.

In the first place, let me make a criticism that many of my brethren will agree with me in. Our medical colleges of to-day are defective in this one thing, they teach the treatment of disease such as may be practised in the city, but which is not applicable in the country. The same may be said of our journals; the articles are almost every one of them written by men in the cities, and under most circumstances the treatment recommended cannot be carried out in the country or the small towns, consequently they are of very little use to the country practitioner. For this the writers and teachers are not to blame, but the fault lies with the country doctor, in that he rarely reports a case or gives his experience in the use of the different remedies.

As I have said of the treatment, so I say of the symptoms. We seldom find in practice just such symptoms in a given disease as is described as characteristic of the disease. The late lamented L. P. Yandell, Jr., used to say "treat the symptoms," and it is to the treatment of symptoms I wish to call attention.

All of the articles published in your journal in reference to this remedy have

been written in the East, except the one by Prof. Hardaway, which comes nearer to the point I wish to call attention to than any other.

It is known that, in some regions in this country, malaria is much more virulent than in others. In the maps published in the census of 1880, these regions are shown, and by referring to them and the authors of these articles, it will be seen that but one article comes from a man living in any of these regions; and as this poison wields a great influence on skin diseases, as well as diseases in general, and as we have this poison to contend with here, it is to the treatment of skin diseases in these regions I will call attention.

My firm belief is that, under these circumstances, arsenic is "*nulli secundus*," for the following reasons: In these regions skin diseases are mostly of malarial origin. Bartholow tells us what all who have tried it will agree to, that arsenic exercises almost a remarkable influence on neuralgia, jaundice, dysentery, diarrhoea, and fevers of malarial origin; then why not on skin diseases?

I assent that it does, and that it has this influence to a greater or less extent in parasitic as well as non-parasitic diseases. When used internally, it is true, it does not destroy the parasite, but the parasite has destroyed the tissues which are affected, and while the parasite may be destroyed by external applications, the tissues are left in such a diseased condition that their destruction will continue unless checked by other influences than merely the parasiticide. Arsenic checks retrograde, and promotes constructive metamorphosis, and in this way has a beneficial influence even in parasitic diseases.

In intermittent fever with recurring rigors, it is rarely possible to cure the disease without the use of arsenic. Quinine may interrupt the prodromes, but it remains for arsenic to eradicate the poison from the system. If it does this in diseases with internal symptoms, why will it not do the same in diseases with external local manifestations?

I have reason to laud this drug because of a personal experience with it.

Several years ago, I was attacked in August with an eczema which for six months resisted all the remedies of the *materia medica*, and all the local as well as the internal remedies recommended by those of experience with this disease, until in the following December or January I was put upon increasing doses of the liq. chloride of arsenic; under this treatment I rapidly improved and was soon well, and have never had a return of the disease. The trouble was of malarial origin, as I knew by the way it was contracted.

While arsenic was not used entirely alone, it was the principal drug, only small doses of the citrate of iron and quinine being given in connection with it.

In my own practice in the last few months, a number of cases of eczema have presented themselves, and have invariably been put upon arsenic in connection with a tonic, and always with the same result.

A short time since, a case of pemphigus came under my care, which was reported to recur every summer; it was at once put upon arsenic, and in less than a week was so much improved as to be considered almost well, since then has not been seen, but judge it is well or the patient would have returned.

These cases prove to me the good effect of this drug in these conditions, and all it gives me such general satisfaction shall continue to use it.

Prof. Keyes says that arsenic is a cutaneous stimulant, and as such should not be used in the acute inflammatory stage, but in the later chronic stage. I rarely wait for any inflammation to subside, especially if I can get a history of malaria, but put the patient immediately on the remedy I consider best to remove the cause, and in this way do away with the inflammation. Eczema is the skin erup-

tion most frequently met with here, but suppose I might say we never meet with what might be strictly called the "weeping eczema," therefore, while under some circumstances it might be well to postpone the use of arsenic until the subsidence of the more acute symptoms, we rarely find it necessary to do so.

I use Fowler's solution in gtt. v. doses, or the liq. chloride of arsenic in gtt. iij. doses and gradually increase if necessary, and I have never yet had it to cause trouble with the digestive organs when used under the above-mentioned conditions. While arsenic has the effect mentioned, if applied externally, even in persons considerably under the influence of malarial poison, I have reason to believe it may produce an eruption such as is described in the July number of your journal.

I should like to see some more opinions in reference to this remedy, especially from those using it in the above-mentioned districts. S. C. BALDWIN, M.D.

PRINCETON, KY., September 24, 1886.

Selections.

NON-VIRULENT ULCERATIONS OF THE GENITALS.

CLINIC OF DR. MAURIAC, PARIS.

NEARLY all the ulcerations which are found upon the genitals are of a virulent nature, that is to say, they are the result of the introduction of a virus, the product of a contagion, and are of themselves capable of producing by contact a lesion of the same appearance. At times, however, we may observe upon the genitals, rarely it is true, ulcerations which have no such origin, and are of an entirely different nature.

The *acne-form furuncle of the glans* is a lesion having certain features of the boil, but a much less rapid course, causing much less local reaction. It appears to begin in one of the follicles of the glans, and is characterized at first by a little hard tumor, which soon ulcerates and bears now a close analogy to the hard chancre.

In its next period, the tumor becomes hollowed out by a cavity of greater or less depth, resulting from the discharge of a quantity of sanguineous pus. Now the lesion closely resembles certain ulcerating chancres, or a gummy tumor. Finally, in its last period, cicatrization takes place with exceeding slowness, very unlike the rapid healing of syphilitic gummata. This acne-like furuncle presents then, as has been seen, great difficulties of diagnosis at times. The evolution of the lesion, the integrity of the inguinal glands, etc., will enable you to distinguish it from the chancre which it most closely resembles.

There is an affection which is generally considered a simple chancre of the gangrenous variety. It is called the *gangrenous affection or anthracoïde of the glans*. Contact plays no part in its development. It is usually found in the groove of the glans as a tumor which rapidly increases in size, and by reason of a very acute inflammatory condition, and perhaps also of some particular condition of structure of the organ, becomes very quickly a mass of gangrene, and what is remarkable, the gangrenous mass is not all proportionate to the size of the erosion

when first seen ; the gangrene extends deeply, and remains for a long time adherent to the adjacent tissues.

It is different with simple chancres which become gangrenous ; here the evolution is much less rapid, and the chancre goes through various changes before sphacelating.

The *anthracoid* of the glans is accompanied usually with intense pain, much greater than that of gangrenous chancre, and similar to the pain of anthrax, ceasing only when the sphacelus has been formed. During the evolution of the disease, although there be often a marked effect on the general health, the inguinal ganglia remain intact and free from pain—a very important point to remember, and one which establishes a sensible difference between this and the gangrenous chancre. In the cases which Mauriac has observed, no condition has been noted, either in the local condition or in the general health, which can explain the development of this affection.

Dr. Mauriac has also observed abscesses of the prepuce with suppuration of the glands of the groin, quite analogous in aspect with those which complicate certain simple chancres, but differing plainly, not only in the conditions under which they appear, but also in the fact that the pus they contain is not auto-inoculable. We may also observe non-virulent abscesses with a chronic course, which are neither associated with a gonorrhœa nor simple or syphilitic chancre. We must also bear in mind that there are to be found upon various regions of the penis affections of which the diagnosis might be rendered extremely difficult by reason of the very peculiar aspect they may take on. It is thus that furuncle of the skin surface of the prepuce can under certain conditions take on absolutely the appearance of a syphilitic chancre. Here again the evolution of the lesion and the state of the inguinal glands must guide the physician in the diagnosis. The *cancroïde*, either observed upon the scrotum or upon the preputial mucous membrane, may simulate in a marked degree the initial lesion of syphilis ; but we may say that in general the diagnosis is only difficult when it must be made at the first examination, without being able to watch its course.

Sclerosis of the glans is the name which Mauriac has given to a special induration quite different from that observed in syphilis, at points where chancres have had their site. This form of hardening of the tissues may be found after simple chancres, blennorrhagia, or any inflammatory condition not associated with syphilis. It is an induration of the glans which produces thickening of the mucous membrane and even augmentation of volume of the organ. The change in structure which takes place in the glans predisposes it to various lesions, such as ulcerations and gangrene.

This balanic sclerosis is most commonly consecutive to a chronic blennorrhagia, although this latter must not of necessity have been particularly violent to cause the disease. It is probable that there exists a particular individual predisposition, similar to that which we observe in certain persons, who, following slight irritations, present congestive spots in the neighborhood of the orifices, as the lips and nose, which last for a long time.

The hardening of the glans may be so marked as to resemble cartilage, and be accompanied by an enormous increase in size. Subsequent ulcerations and gangrene may cause numerous fistulous tracts.

There is a serious difficulty encountered in diagnosis, for at first it seems that such hardening must be symptomatic of an infecting chancre located within the urethra. In simple induration, the induration is always symmetrical, occupying, in an equal degree, both sides of the meatus, whereas in chancre it is much more

irregular. Here again the state of the inguinal glands is of the greatest importance, for in simple induration they are never involved.

Finally, although exceptional, non-virulent ulcerations of the genital organs hold a sufficiently important place in this special part of pathology not to be neglected in diagnosis. The physician should not regard all lesions as of necessity specific or virulent because they occupy the genital organs.—*Journal de Médecine et de Chirurg.*, July, 1886.

HARD CHANCER OF THE VAGINA.

AN exquisite case of hard chancre of the vagina is related by Dr. Bockhart, in the *Monatsh. für pract. Derm.*, No. 12, which is interesting from the manner in which it originated, as well as from the fact that the hard sore is very rarely found on the mucous membrane of the vagina, partly because of its histological formation and because, too, sores here heal quite rapidly. A woman who had never before contracted syphilis, although she had often had coitus with an infected man, experienced pain after each connection during the fortnight before she was seen, and after each intercourse drops of blood came from the vagina. Examination showed an undoubted hard chancre in the middle of the posterior vaginal wall. There were no secondary symptoms. The man had moist patches about the frænulum. The origin of the infection was this: The man, who was in the habit of performing the act several times during the night, always used at the first onset a so-called *stimulating condom* to increase the woman's genital excitation, and left it off during subsequent copulation. The instrument mentioned consisted in a thick rubber condom having rows of rubber prongs on its surface so arranged that they flatten out as the penis enters the vagina, but upon withdrawal stand out and irritate the vagina, and, undoubtedly, when often used, cause erosions. An erosion having been produced in this way, the syphilitic virus found entrance from the man's mucous patches, and the perfect induration resulted, where, without the loss of substance, spontaneous healing would have been looked for. Symptoms of constitutional syphilis soon appeared.

LOCAL BATHS OF CORROSIVE SUBLIMATE IN THE TREATMENT OF CERTAIN SYPHILIDES.

IN a communication to the French Society of Biology, June 10th, 1886, *Le Progrès Médical*, Dr. Gilles de La Tourette claims excellent results from the use of baths, and local applications of corrosive sublimate solutions in plantar and palmar syphilides, especially those resembling psoriasis.

The author had observed the success of this treatment at the St. Louis Hospital in 1880, as employed by the late Dr. Hillairet, in generalized papulo-squamous syphilides. Kaposi has recommended this same treatment, advising solutions of the strength of one gram to each one hundred grams of water.

This strength has seemed to the author too irritating in many cases, and almost intolerable where fissures are present.

He considers Van Swieten's solution (Hydrarg. bichlor., Ammon. chlorid., āā gr. x.; Aquæ, Oi.), diluted one-half, quite strong enough for most cases. The results of treatment in sixty-five cases are recorded, and interesting observations given. These lesions on the palms and soles appear usually in the first six or eight months after the disappearance of the chancre, and are benign if the disease is receiving proper treatment. When, however, these lesions first appear from five to eight years after a primary syphilis where treatment has been neglected, they are not so mild. The palms and soles, especially the latter, become

covered with hard crusts, and the natural creases and folds become fissured and exuding and are painful. A sensation of heat is felt in the palms and soles, especially at night.

The treatment for both forms is the same, and a local bath of ten minutes' duration, morning and evening, suffices to cure in ten or fifteen days an eruption which has resisted internal treatment for six weeks or two months. In three very obstinate cases, one of which had lasted for two years and a half, despite all treatment (anti-syphilitic not having been tried), the employment of the local baths demonstrated, by a rapid cure, the specific nature of the disease which had up to this time been ignored. This mode of treatment is then at once curative and diagnostic, and should not be neglected in doubtful cases.

It has appeared to the author that baths given as hot as possible gave better results than cold local applications. With regard to the contagiousness of the exudation from these palmar fissures, he states that it is difficult not to so regard it, when we know the contagiousness of mucous patches, which are of much the same nature, being the papulo-erosive lesions of the mucous membranes co-existing with papulo-squamous lesions of the skin.

In conclusion, the statement is made that this treatment was applied to a case of erythematous lupus which had existed for six years upon the knee of a young lady of eighteen. The cure was completed at the end of two and a half months.

DIAGNOSIS BETWEEN THE INITIAL SCLEROSIS OF SYPHILIS AND LOCAL CONTAGIOUS HELCOSE (SOFT CHANCRE).

DR. ERNST FINGER (*Vierteljahrsschrift f. Dermat. und Syph.*, 1885) lays down the following propositions concerning hard and soft chancres and their diagnosis.

From the observations of others and from those of the author himself, he believes that induration of a primary sore is not a positive sign of syphilitic infection and should not be so regarded. Induration is found in secondary and tertiary lesions, and also in inflammatory infiltrations in syphilitic individuals.

Again, non-syphilitic affections after various irritants take on a decided induration at times. Finger, therefore, concludes that induration is not an absolute pathognomonic sign of the initial lesion of syphilis; its presence being no more a positive sign than its absence a sure negative symptom. Entire surety of the syphilitic nature of an initial lesion is first possible (confrontation being expected) when the indolent glandular swellings appear, that is to say, in about three weeks after the infection.

Now according to the author, from the nature and mode of increase of micro-organisms, and consequently of the syphilitic virus, it is physiologically improbable that the disease should remain localized for three weeks, and consequently he does not favor the excision of the local sclerosis.

From the results of recent inoculations, Finger endeavors to uphold the belief that a soft chancre can be produced in healthy persons by the inoculation with pure pus. Inoculations on the genitals from non-syphilitic traumatic ulcers produce on the individual himself, as well as on others, typical soft chancres. This quality seems to him to depend really upon the seat of the original ulcer upon the genitals, where the virulence is increased by the uncleanness so commonly found. In opposition to the objection of dualists that syphilis, often only a local affection, produces soft chancre, he opposes the fact of the well-known immunity of certain individuals—an immunity which is observed in those who have passed through acquired or hereditary syphilis, and in healthy

children of syphilitic parents, as also an immunity against syphilitic virus which has not yet been explained.

HOMŒOPATHIC TREATMENT OF RHUS POISONING.

MR. TAFEL, in the *Homœopathic Recorder* for July, says: "While there are ever so many antidotes, no remedy has as yet been found successful in all cases of poisoning by Rhus."

The writer has had considerable experience with the effects of the plant on the skin of his employés, who collect the yearly supply of fresh leaves for the pharmacy, as well as in others. In 1871, a five-year-old boy who had crept through some Rhus tox. brushes became so poisoned that the face was swollen and the eyes closed, and the abdomen and genitals were implicated. On the third day, in spite of all remedies, the face was covered with a thick gray crust. Two doses of *Psorinum* 400 (Hering) were given four hours apart. Within an hour the itching grew less. Next day the crusts died, and in three days they were gone and the boy was soon well. In his own person, where the face was puffed up and itchy the morning after gathering the plants, he took one dose of the 28,000 potency of Rhus tox. Within less than an hour his face felt as though a cooling lotion had been applied, and by evening the swelling was almost gone.

The boy of five, previously mentioned, was a second time poisoned; the face, neck, hands, and arms being "blotched with a terribly itching eruption; he received one dose of Rhus tox. 28,000 potency, and by evening the face looked natural and the itching was gone." He subsequently treated three cases with this same strength of the Rhus, giving only two powders, and "within twenty-four hours they had been cured and stayed cured." The next season, he says, when he wanted to repeat this success, the remedy, for some unknown reason, would not respond, and that season he saw as prompt effects in several cases from *Bryonia* 200. However, he considers *anacardium* 200 and *croton tiglium* 200 as the standbys.

This year Mr. Tafel says four of his men gathered, in one day, two hundred and sixty pounds of fresh leaves. Each man and the superintendent took, before starting, a dose of *anacardium* 200, and a second dose upon their return. Two men escaped entirely; one had a slightly inflamed face the next morning, but after a third dose the redness decreased, and on the third day he was well. The superintendent was slightly affected on the wrists and arms; he took three doses of *anacardium* and was well on the fourth day.

Bryonia is said to remove the sensation of fulness in the scalp, the rheumatic pains in the chest increased by respiration, palpitation, dyspnoea, and painless rigidity of the neck.

At the homœopathic pharmacy in San Francisco, they generally give the third or sixth potency of *Rhus Californica* as an antidote, with apparently good success.

THERAPEUTICAL ACTION OF ALVELOZ.

DR. LANDOWSKI has devoted considerable study to the therapeutical action of the juice of alveloz, the Brazilian remedy for cancer. His experiments have extended over a period of one and a half years, and from their results he draws the following conclusions:

1. This preparation is worthy of a most careful experimentation; it unites with a powerful escharotic action the property of dissolving organic tissues, and its action may be compared to a powerful caustic, double the strength of papaine.

2. The destruction of pathological tissues is promptly effected, and may be graduated, so to speak, layer by layer. The juice may then be employed when, from any cause, the bistoury is not practicable.

3. The application of the new topic is quite convenient, the most powerful effects may be obtained by simply painting with a brush. A dressing with a solution of the sublimate (1 to 2,000), or borated vaseline, may afterwards be made.

4. In order to obtain the desired effect, the juice should be fresh, since it rapidly loses its properties.—*Bull. Gén. de Thérapeutique*.

THE THEORY OF SYPHILITIC INFECTION OF THE MOTHER BY THE FŒTUS.

SOME three years ago, Dr. Roig Bofill read a paper before the Royal Academy of Medicine and Surgery of Spain, in which he took the ground that syphilis could not be communicated from the foetus to the mother, basing his views upon the anatomical facts opposing such a theory. Recently Dr. Charles Shadek has published, in Kieff, a brochure in which he also endeavors to refute the theory of the *choc en retour*, or syphilis by conception. The author believes this theory, advanced over sixty years ago by Gardien, has held its ground simply from the fact that its opponents have contented themselves with a simple negation, instead of citing proofs and of submitting the assertions of the partisans of this theory to rational criticism. He asserts that the examination of the mother in such cases shows conclusively that the lesions are of greater age than they could be, had the disease been acquired from the foetus. He says also that no facts have ever been brought forward to show that solid substances or formed elements can pass from the foetus through the placenta into the maternal circulation. And as at the present time it is admitted that syphilis can be transmitted only through the medium of formed elements, he says, it is therefore highly improbable that the child, while still in the womb, can communicate the disease to its mother.—*Revisita de las Ciencias Médicas*, August, 1886.

COLLODION IN VARIOLOUS ERUPTIONS.—At a recent meeting of the Société des Hôpitaux, M. Comby stated that the different local remedies which from time to time have been recommended for arresting the variolic eruption, have all in their turn been rejected as dangerous. He mentioned the following case as an example: A female patient entered the St. Louis Hospital with small-pox. Her face was covered with collodion. Papulæ appeared on the trunk and limbs; the face seemed to be free from eruption. On April 11, papules appeared on the upper lip and raised the collodion. The eruption spread entirely over the face, and showed through the covering of collodion. The patient suffered intolerable agony. An attempt was made to remove the collodion, but the patient suffered such pain that it had to be given up. The portion of collodion that was separated from the face left the derma exposed to the air. The eruption, which was discrete, semiconfluent, extended to the limbs; and the face was transformed into a running wound most offensive in its odor. The temperature rose to 39.4° Cent. (102.3° Fahr.). On April 15, the patient became delirious, and died. M. Comby considers that the patient died from the same morbid process that kills patients with serious burns. At the necropsy, all the viscera were found to be healthy. If the patient had not died, she would have been terribly disfigured by buccal or palpebral atresia.—*British Med. Journal*.

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Original Communications.

NOTE RELATIVE TO THE BULLOUS ERUPTION OCCURRING AFTER
INGESTION OF THE IODIDE OF POTASSIUM.

BY

JAMES NEVINS HYDE, M.D.,

Professor of Skin and Venereal Diseases, Rush Medical College, Chicago.

AT this date, it is almost necessary to introduce a discussion of the particular subject to which this note refers, with an apology. In the year 1879, following the late Drs. Tilbury Fox, and Bumstead, Dr. Taylor, and others, I read before the American Dermatological Association a paper entitled "A Contribution to the Study of the Bullous Eruption Induced by the Ingestion of the Iodide of Potassium."¹

Since that date, valuable contributions to the same subject have been made abroad by Thin,² Hallopeau,³ Lindsay,⁴ Besnier,⁵ and Pellizari.⁶

In our own country, exceedingly interesting and important papers bearing more or less directly on the same theme have been published by Drs. Van Harlingen,⁷ Morrow,⁸ and Tilden.⁹

¹ Archives of Derm., October, 1879.

² Medico-Chirurg. Trans., 1879, p. 189.

³ L'Union Médic., No. 41, 1882, p. 481.

⁴ British Med. Jour., March 19, 1884, p. 602.

⁵ Annales de Derm. et de Syph., March, 1882, p. 168.

⁶ "Nuovo Contrib. allo studio d. Eruz. Iodiche." September, 1884; also Arch. of Derm., July 1, 1881, p. 267; and eleven other journals named by the author.

⁷ Arch. of Derm., 1880.

⁸ JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, December, 1884; April and May, 1885.

⁹ Reprint of Report made to the Annual Meeting of the Mass. Med. Soc., June 9, 1885.

It is quite unnecessary to retrace the ground well covered by these writers, and scarcely needful to add to the list of clinical facts already recorded, which demonstrate the main point, viz., that ingestion of the iodine compounds is occasionally followed by the appearance of a bullous exanthem.

This note relates to a single point of interest in this connection, and the following cases are narrated in the briefest form merely to illustrate what follows :

CASE I.—On the 15th of March, 1886, a fairly well nourished female infant, 7 months old and suckled by a pallid-faced mother, was presented for examination. Its previous history was submitted in writing by the physician in the town where the family resided. According to this account, six weeks before, the child had suffered from a fever the exact nature and origin of which was not known. Three weeks before the present date, the eruption now visible appeared first on the neck, and then gradually spread over the face, scalp, and dorsal aspect of the hands and forearms. The lesions at first resembled those of chicken-pox, some rapidly desiccating; others persisted and enlarged. Before and after the appearance of the eruption, the iodide of potassium had been administered in one-grain doses.

When examined, the child's face, the dorsal aspect of the hands and forearms, and, to a less extent, the scalp were found covered with isolated, whitish and reddish-yellow, split-pea to marble-sized, firm, flattened, and slightly umbilicated lesions, resembling molluscous tumors. A few looked rather like vesicles. The two upper limbs were nearly similarly affected, but there was decided asymmetry of distribution on the face. The contents of these singular lesions were inspissated, thick, grumous, and of such consistency that there was no escape on rupture of the containing wall. They showed no trace of iodine when chemically tested.

A single and remarkable lesion existed on the left cheek. It was as large as the longitudinal section of a turkey's egg, flattish, ovoid in contour, with a narrow areolar blush, and raised about six millimetres from the surface. It had rather the lighter of the several shades presented by the eruptive lesions, being milky-whitish in color. It was evidently constituted of a group of lesions of the kind to be seen upon the hands. This patch had a remarkable, deforming, and formidable appearance, and would have aroused my anxiety if I had not, after its examination, felt confident that I had before seen such lesions disappear under very simple management. There were a few less perfectly developed button-like vesicles on the upper and anterior face of the trunk.

The eruptive lesion in this case were dusted with an antiseptic powder, and the nursing mother was given a ferruginous tonic. In two weeks more, a letter was received from the father from which the following is an extract:

"The spots have all dried up; only a slight redness of the skin remains where they once were."

Regarding the tender age of the child, it was not deemed justifiable to experiment in the reproduction of the eruption by a repetition of the

dose. The examination of the urine passed upon a napkin was negative as regards the presence of iodine, but not satisfactory as to the quantity and character of the specimen secured for examination.

CASE II.—On the 4th of February, I was summoned to the Hospital to pronounce upon several cases of disease of the skin. Among the patients was a cachectic-looking, poorly-nourished, sallow-faced lad, 15 years old, who had lately undergone a surgical operation for necrosis of the right femur. He was completely stripped, save as to the surgical dressing of the limb upon which the operation had been performed, and his body was then seen to be quite regularly and generally covered by eruptive lesions of two kinds. That which predominated decidedly as to extent and vividness was composed of large annular and circinate plaques, dull-red in shade, with a more or less clear and unaffected centre, extending, with diameters varying from several centimetres to a half metre or more, over the trunk and limbs. In a few well-marked areas, the centre was not clear, but occupied by a dull-red, diffusely infiltrated and raised, scarlatiniform patch, with defined circular or ovoid outline. In some parts, the eruption was of a dull brownish hue, these colors changing markedly during a hystero-epileptoid convulsion occurring during the course of the examination, at which time the patient partially lost consciousness.

Besides these extensive giant areas resembling certain forms of erythema circinatum here and there, more particularly about the fingers and hands, though elsewhere also, were distinct blebs. These were pea- to small nut-sized, destitute of areolæ, globular, well projected from the level of the surrounding integument, and, for the most part, of light-bluish leaden color, containing, in every case when not ruptured, a clear serum. After rupture, there was left in those whose history had been traced for several days dark-reddish, pea-sized, and somewhat smaller circular maculations where repair occurred beneath superficial crusting. Some of these vesicular and bullous lesions were found in connection with the scarlatiniform plaques of circular outline; others, however, occurred where there had been no involvement of the skin by any pathological process.

I asked, as soon as the examination of the patient was concluded, whether the iodide of potassium had been exhibited in his case, and was told that no medicine of any kind had been given. It was natural then to look for an exciting cause in the antiseptic dressings applied to the wound of the thigh; but while investigating this subject, one of the internes was called aside by the nurse, who told him that the patient had been kept steadily on the iodide of potassium in fifteen-grain doses ever since the eruption appeared, and but a brief time before. I did not hesitate to decide as to the origin of the exanthem on this showing. In a week after the discontinuance of this drug, the eruption faded completely, and was reappearing in the same form on a second exhibition of the potassic iodide in the former doses, when he was removed by his friends from the hospital.

In this case, iodine was found in the urine, but none in the contents of the vesicles and bullæ.

My personal observation of the eruption now under consideration has

been limited to the facts described above, with a single and not unimportant exception which, unfortunately, I am not justified in reporting as having been carefully observed.

In the year 1880, I was passing the office of a physician who was also a personal friend, when he called me to step inside for a moment, not with a view to a consultation, but because he had a child in his arms whose face and hands were covered with such an "unusually abundant crop of mollusca" that he wished me to see them. I was in the room for but a moment, yet in that time I could observe that the child was healthy looking, and about two years old, with face and hands thickly studded with small marble to pigeon's egg-sized, firm, reddish-yellow, slightly umbilicated, semi-solid lesions, with contents of the so-called sago-grain type. As soon as my eyes rested on this eruption, I detected its resemblance to that described by me in my paper written during the preceding summer. I told my friend that the case was not one of molluscum, and asked whether before and since the first appearance of the eruption he had administered the iodide of potassium. He confessed that he had done this for relief of another ailment. As the mother was waiting, I had but a moment in which to complete the interview. Later, this physician informed me that the eruption disappeared, undergoing involution by the formation of crusts, after the drug was discontinued.

I note it as a curious fact that no one of the physicians in the cases described above, when confronted with this singular eruption, seems to have had the remotest suspicion that it had resulted from his prescriptions.

On the basis of this confessedly limited experience, it is of course improper to draw positive conclusions. I am, however, as a result, impressed with the conviction that the writers on this subject have confounded different forms of eruption, and that, sharing their error, I have myself contributed to the confusion. Certainly two distinct and different types of bullous or quasi-bullous eruption have been produced by ingestion of the iodide of potassium under my observation; and if the polymorphous rash be regarded as distinct, which I am not sure that it is proper to insist upon at present, no fewer than three sub-varieties or sub-forms must be admitted. The purpose of this note is to call such attention to this fact that subsequent observers, surveying the entire field with a view to its fresh study, may at least be awake to the possibilities of error. It should be added that, if any credit attaches to the establishment of a distinction of this kind, it is wholly due to the late Dr. Tilbury Fox. His early statements on this point somehow failed to attract the attention they deserved; and I, with others, have up to the present committed the error of ignoring the distinction he was early in making.

The first sub-form of bullous eruption induced by ingestion of the iodide of potassium is clearly of a bullous type, pure and simple. It is a noticeable and interesting fact that most of the cases tabulated under

this title are of this character. The patients are commonly well advanced in years, often decidedly cachectic, and affected with syphilitic or other grave disease. For example, of ten serious cases in this group, five proved fatal, and an equal number suffered from cardiac complications. The patients observed by Morrow, Thin, and Hallopeau may all be regarded as illustrations of the first and most common, purely bullous manifestation of the iodic exanthem. The pathogenesis of this affection, whether explained in one or another of the methods well-described by Tilden, cannot be entirely disassociated from the asthenic, cachectic, and even in cases almost moribund condition of the patient in whom the eruption appears.

In what may possibly be regarded as a second subform of this exanthem, there are di- or polymorphic symptoms. Here, more or less typically perfect bullæ are commingled with papules, tubercles, and scarlatiniform or other patches of disease. To this class may be assigned Pellizari's case, one of Morrow's cases, the second of those described above by myself, and possibly also a curious and very interesting case reported from the hospital practice of Dr. J. E. Graham, of Canada,¹ where the eruption consisted of numerous vesicles developed in connection with acute erythematous symptoms.

It is, however, to the third sub-form of eruption, hitherto regarded as identical with the others, to which I desire to call special attention. This is illustrated by Dr. Tilbury Fox's cases, one of which concerned a man only twenty-seven years of age; a very interesting case reported by T. Calcott Fox,² in the person of an eight months' infant; and the three children observed by me. Two of the latter were pallid, fretful, and poorly nourished, but were not in a state that could be properly described as cachectic.

Now, Dr. Tilbury Fox began his interesting paper by stating that the eruption under his observation was "quasi-bullous;" and this term is repeated by him several times in his paper. The plate he gives represents very perfectly the rash seen by me three times. This illustration is, however, far inferior to the well-executed lithograph reproducing the clinical aspect of the face and hands of Morrow's patient; and, as stated by me in my first contribution to this subject, is wholly unlike the Sydenham Society's plate, entitled "*Hydroa from the Iodide of Potassium.*"

Fox characterizes the eruption seen by him as "odd." In one, there was a suspicion of variola. The following are his significant words: "It

¹ The Canadian Practitioner, 1884, p. 255, "A Case of Hydroa with Peculiar Iodic Eruption." This paper seems to have been overlooked by Dr. Morrow in making up his statistics.

² Brit. Med. Journ., Nov. 21, 1885. This case also should have been included in Morrow's list.

is my opinion that the designations, bullous and pemphigoid, convey a most incorrect idea. The eruption is not made up of true bullæ, nor do the spots develop like true bullæ. The affection is in no way related to true pemphigus, or to hydroa as defined by Bazin who originally described it. In the two cases, the particulars of which are here recorded, the eruption is said to have been papular in an early stage, and to have had, a little later, solid bases. In some parts they resembled acne simplex; in others, they vesiculated and subsequently simulated variolous pustules; at a later stage, ecthyma; and finally, bullæ with milky contents, or discharging smegma; and these bullæ possessed peculiar solid bases wholly unlike true bullæ; answering rather to large molluscum contagiosum tumors with semifluid instead of more solid contents."

In yet other parts of the same paper, the writer describes the lesions recognized by him as a kind of "papillomatous growth," "a white pultaceous, fungatory mass," "spots" filled with "excessive and altered secretion of sebum," and still other suggestive phrases.

Without apparently recognizing the fact that he was so accurately following in the footsteps of his predecessor, Dr. T. C. Fox, when describing the lesions appearing in the eight-months-old child under his observation, uses the term "condylomata" as one suggesting to his mind the appearance of the lesions. He also describes solid bases to the vesicles appearing on the surface, which had, precisely as in one of the cases here reported by me, been taken at one time for varicella.

Both of these writers employ the exact terms which might be used to describe the lesions seen three times by myself; and I deem it within bounds to add that they are expressions which would not properly apply to the eruptive lesions recognized by most authors who have described this exanthem. In none of the children seen by me were there true bullæ, of the kind described in the second of the two observations here reported. The lesions are all semi-solid, split-pea to small palm-sized in extent, filled with semi-pultaceous, sago-grain like, whitish to dark-yellowish contents, which would not flow freely forth on rupture of the roof-wall and in which their appearance very decidedly suggested umbilication. I now believe that I was in error when I stated in my former paper that this feature was due to collapse of the roof on the contents of the chamber after involution had begun. I am inclined to think that this appearance is characteristic of the special form of eruption under discussion, and due either to the tendency to grouping, or to follicular attachments of some portions of the epidermis overlying others in a different plane.

This much explained, I deem it safe to leave the question to be solved by further observation, which I feel confident will be had. I am aware

that personally I have seen this eruption but three times in my life; but on the last occasion, so vivid was the impression produced by an earlier experience, that I felt morally certain, before the fact was known to me, that the iodide of potassium had been administered to the child, and was solely responsible for the apparently formidable results. I cannot believe that this same impression could be at any moment produced by merely inspecting bullæ on a child's skin. It is, of course, barely possible that the differences to which attention is here called are associated with the tender age of the subjects observed, but as precisely the same features were seen in the adult cases registered by Fox, I need not dwell on this point.

With this limited experience, it would be, of course, improper to formulate definite conclusions; and I therefore summarize the suggestions advanced above, in the form of interrogative propositions as follows:

1. Are there not three sub-forms of the bullous exanthem developed after ingestion of the iodide of potassium in certain individuals?

2. Is not the first and most common of these, to be generally recognized in persons of advanced age and cachectic condition, the rash being then exhibited in the form of typical bullæ?

3. Is there a second, and still rarer sub-form in which the eruption is displayed in di- or polymorphic manifestation, typically perfect bullæ being then commingled with papules, tubercles, scarlatiniform maculations, or with other and different lesions?

4. Is there not a third and rarer sub-form, a quasi-bullous rash, to be recognized most often on the face and dorsal aspect of the hands and forearms of infants and children; where the lesions are semi-solid, slightly umbilicated, and filled with sago-grain-like, grumous, inspissated, yellowish, whitish, and darker-colored contents, which do not collapse after fracture of the encircling wall, but which, without distinct outpouring of the contents, may shrivel and desiccate to a crust after suspension of the drug inducing the eruption?

5. Is this last-described lesion one to be recognized solely as the result of the ingestion of the iodide of potassium, never under other circumstances, and one as peculiar to the special condition it represents, as is the gumma to syphilis?

GONORRHEA FROM MALE TO MALE.—In a recent number of the *Medical News*, Dr. Winslow reports an epidemic of an unusual nature occurring in an institution near Baltimore. One boy contracted gonorrhœa from a girl outside of the institution, and subsequently cohabited with a boy, causing an inflammation of the rectum. The fact that ten boys were found to be suffering from gonorrhœa showed to what an extent the filthy habit, to which some confessed, was prevalent.

INFLAMMATION OF THE HAIR FOLLICLES WITHIN THE NARES.

BY

W. A. HARDAWAY, M.D.

I HAVE read with much interest in the October number of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES an abstract entitled "Eczema of the Nares." While eczema of this region is common enough, and the description given by Kiesselbach is quite accurate, I agree with Dr. Moldenhauer in the statement that we have here to deal with two distinct clinical and pathological conditions, viz.: (1) eczema and (2) inflammation of the vibrissæ, which latter is in effect a folliculitis barbæ. I wish to speak of the latter very painful and annoying affection only. Although I had long possessed both a professional and—much to my regret—personal acquaintance with this really distressing malady, my first knowledge of the literature of the subject was made in the course of reading certain "Clinical Communications to Practical Medicine," contributed by Dr. (now Sir) Dyce Duckworth to the St. Bartholomew's Hospital Reports, vol. xv., 1879. In this place, speaking of the great value of glycerin in painful forms of follicular inflammation of the skin, he remarks that "in particular there is a form of follicular inflammation, not uncommon about the nostrils, where poultices cannot be applied. A sort of "blind boil arises in connection with the vibrissæ, accompanied by intense pain and tension. Suppuration is not common, and resolution occurs as a rule. The application of pure glycerin, by means of a camel's-hair pencil, both internally and externally, is a source of much relief and comfort."

It is likely that there are a number of etiological factors that enter into the production of this affection, but I wish especially to call attention to the frequency with which it seems to be associated with a broken-down state of health. I have noticed it quite often as a consequence of a "fagged-out" condition of mind and body, following upon unusual or prolonged mental activity. The pain may in some cases be very severe, the parts feeling as if a burning coal were being held to them. The acuteness of the suffering is due to the fact that in these cases we have an inflammation of the hair follicle in a place where there is little room for the extension of the inflammatory process; the parts are rigid and do not readily yield, and give rise to the same symptoms that occur when an abscess affects the palmar or plantar regions. The skin of the nose, such is the intensity of the inflammation, also becomes intensely red, and at the end of the process not infrequently desquamates. Suppuration is comparatively rare, and the disease may last from a few days to several weeks; in some

cases creeping along, now and again a new follicle becoming involved, for months. In these chronic cases, the patients will often consult you for the external redness, not connecting it with the inflammation about the vibrissæ.

As regards the internal treatment, and such treatment I have found nearly always to be necessary, it is well to correct any obvious errors of health, especially inquiring into matters of digestion, and then to institute a general tonic course. The following combination has appeared to me particularly serviceable :

R Ol. morrhuae.....fl. ʒ iv.
 Pancreatin saccharat.... 3 i.
 Pulv. acaciæ.....q. s.
 Glyceriti hypophosphiti,
 Syr. calcii lactophosphatis,
 Aquæ.....āā fl. ʒ iv.
 Ol. gaultheriæ.....gtt. xxx.

M. et ft. emulsio. S. Tablespoonful three times a day after meals.

I generally precede this, however, with the sulphide of calcium for a few days, giving one-tenth grain every third hour. If the case is seen early, this latter treatment is undoubtedly serviceable. In the local management of the acute stage, I have taken advantage of Sir Dyce Duckworth's suggestion as to the utility of glycerin, and, I think, improved upon it. Instead of using glycerin pure, I add to it two drachms of Squire's glycerole of the subacetate of lead.¹

This I direct the patient to apply freely, by means of a hair pencil, to the inside and outside of the nose. At the same time I recommend the parts to be fomented several times a day with water as hot as can be borne. I also regard it of much moment that the hairs be plucked from these inflamed follicles—a proceeding which often goes far towards abating the process. When suppuration occurs, the knife should be employed, and sometimes, even in the earliest stage, free local depletion serves a good purpose.

After the pain and tension have greatly subsided, there remaining only much soreness and external redness, I am in the habit of employing the following ointment, which I first saw in Van Harlingen's valuable and practical handbook, where it is recommended in certain forms of eczema :

¹ The formula of this valuable preparation is as follows : Acetate of lead, 5 parts; litharge, 3½ parts; glycerin, 20 parts, by weight. Mix and expose to a temperature of 350° F., and filter through a hot-water funnel. The clear, viscid fluid resultant contains 129 grains of the subacetate of lead to the ounce.

℞ Squire's glycerol. plumbi subacetat.....fl. 3 ss.
 Glycerini.....fl. 3 iss.
 Ung. aq. rosæ ̄ i.
 Ceræ albæ.....q. s.

M.

Finally, when the hairs in the nostrils are not too numerous and are quite large, and when this annoying disease is prone to numerous relapses, it may be advisable to destroy the vibrissæ by electrolysis.

2303 Olive St., ST. LOUIS, MO.

ON THE VALUE OF ARSENIC IN THE TREATMENT OF DISEASES OF THE SKIN.¹

BY

R. W. TAYLOR, M.D.,

Surgeon to Charity Hospital.

THOUGH I cannot indorse the general tenor of and inferences to be drawn from Dr. Fox's article, "On the Useless Administration of Arsenic in Diseases of the Skin," I think we have reason to be pleased with the condition of affairs which prompted its publication. While he justly calls attention to its too frequent routine use, and draws the line, I think, too closely around its sphere of usefulness, he by implication shows that to-day our resources in the treatment of diseases of the skin, in the way of topical, hygienic, and thermal adjuvants, and medicinal agents, is so great and measurably precise, that we are in a position very far in advance of our predecessors, and that we can afford to look calmly and critically on the therapeutic effects of this remedy, and seek to determine, as nearly as possible, what it will and what it will not do. While my studies of the doctrines of the various schools of dermatology have taught me that local causes play a large, if not the most important part in the causation of skin diseases, I have not lost sight of the fact that various systemic or internal conditions do exist as etiological factors in them, and that treatment should be based on broad grounds rather than on narrow and exclusive ones. Therefore, while I employ all the most approved topical remedies, I invoke the aid of internal agents where they may be useful. Permit me, therefore, in this present symposium, to add my mite, and to briefly state my results with arsenic in the treatment of skin diseases.

In general, I think arsenic is of value in the more superficial affec-

¹ Read before the N. Y. Dermatological Society, October 25, 1886.

tions, particularly in those of the epidermis, in those having a neurotic origin, and it is particularly beneficial in cases—not infrequent—in which malaria acts as a complication.

I have observed marked benefit in many cases of acne simplex, either alone or in combination, as the case required, with alkalies, iron, and tonics. In some cases of acne indurata, it also has been of decided value, while I have found little benefit from it in rosacea.

In my experience, the value of arsenic is, I think, most strikingly shown in its effect on certain lesions of a scaling hyperæmic character and of neurotic origin. The limits of this paper will not permit me to give the facts in detail which are to be found in an article by me, entitled: "On a Peculiar Ringed Affection of the Prepuce and Glans," *Archives of Medicine*, page 237, Vol. XII., 1884. A perusal of the results obtained by the use of arsenic in those cases will, I think, convince a skeptic of its great value.

In pemphigus, my experience has been in accord with Hutchinson and others as to the decided beneficial action of this agent, and I recall several severe cases of herpes progenitalis of neurotic origin, in which marked amelioration of the symptoms and shortening of the course of the diseases was due to arsenic in full and quite long-continued doses.

While I have seen benefit from an alkaline treatment of lichen planus, I have seen many cases in which arsenic alone proved curative. In several instances of chronic and relapsing dermatitis herpetiformis, or dermatitis multiformis, it has proved the one agent which would abort and prevent the distressing outbreaks.

Our knowledge of the etiology and treatment of chronic urticaria is, to say the least, by no means precise, and we hail with delight any remedy of value. In several cases with marked features, I have seen much amelioration and even perfect cure from large and persistent doses of arsenic. Again, in an allied affection, erythema nodosum, arsenic has proved of decided value either as the active agent or as an adjuvant to iron or alkalies. In this connection I may say that it is in such cases as these, which are often rebellious and discouraging, that the great therapeutic power of this agent may be observed.

I am disposed to employ arsenic in a limited manner in the treatment of eczema, yet there are cases in which it will prove of benefit. In cases of spots of nummular eczema scattered over the body with a tendency to relapse, in some instances of eczema of the fingers and hands not caused by local irritation, chiefly in neurotic persons and those of poor fibre, I have seen markedly good results. Then again, in some few cases of erythematous eczema of the face and of eczema squamosum, I have seen it bring about a cure.

I think that the routine use of arsenic in psoriasis, and its consequent frequent failures, has much to do with the disrepute of arsenic, such as finds expression in Dr. Fox's article. There are many cases of psoriasis in which arsenic is positively harmful, if used in true therapeutic doses. I refer to those florid, plethoric cases in the adult and middle-aged, in which this stimulant of the cutaneous vaso-motor nerves is wholly out of place, and in which mercurial purgatives, aperient waters, and alkalies are indicated. My experience with arsenic in psoriasis teaches me that it is of value almost entirely in those cases in which the patches are of a pink color, often found in subjects who need tonics. I might enter into greater detail on this point, but want of space forbids it.

In syphilitic eruptions, particularly of the scaling papular and tubercular varieties appearing late in the first and in the second years and even later, arsenic will frequently prove a valuable adjuvant to mercury and iodide of potassium, alone or in combination. The same remarks apply to some forms of malignant precocious syphilides, and to the ulcerative forms of intermediary or late development. Stated concisely, I think it is of most value in syphilides attacking the derma more or less superficially, and of little value in infiltrations of the connective tissue. The existence of Donovan's solution is evidence that the value of arsenic and mercury combined was learned many years ago.

We certainly possess in arsenic an agent of much and extended value as an adjuvant to the iodides and bromides. It is needless for me to speak in praise of this remedy in preventing the unpleasant effects of these agents upon the skin. Who is there that has not had cases in which he would have been compelled to give up the use of iodide and of bromide of potassium but for the salutary effect of their combination with arsenic?

Though perhaps not germane to this contribution, I feel that this is an excellent opportunity to express my warm praise of arsenic as an adjuvant in some cases of persistent syphilitic adenopathy, both in the secondary and tertiary stages. Those who treat many syphilities will call to mind cases in which the submaxillary and sublingual glands have become hypertrophied and perhaps sclerosed, and cases in which the cervical and inguinal ganglia have become enlarged and hardened late in syphilis—a condition very often attended with emaciation and cachexia. In many such instances, I have seen our usual remedies of no avail until their combination with arsenic, when the swellings have gradually melted away.

These are the most prominent instances which have made me a believer in the efficacy of arsenic. To be of value, it must be used carefully, intelligently, and persistently. Routine practice, in general, means care-

lessness, want of precision and slipshod diagnosis. Used in that manner, quinine, iodide of potassium, and the preparations of mercury themselves would fall into disrepute and disfavor.

I am not one of those who disparage Fowler's solution, since I have found it efficient in action and of easily adjusted dose. Arsenious acid and arseniate of soda in solution, pills, or in tablets, are also efficacious. The basis upon which the successful use of arsenic depends is, therefore, the care and accuracy of diagnosis, the intelligence shown in drawing the therapeutic indication, and the judgment, care, and persistence with which the remedy is handled.

40 WEST 21ST STREET, N. Y.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

166TH REGULAR MEETING, OCTOBER 26, 1886.

DR. ROBERT W. TAYLOR, *President, in the Chair.*

DR. SHERWELL presented a

CASE FOR DIAGNOSIS.

W. K., male, æt. 35. Now has an erythema covering the trunk and limbs, the face being entirely free. The eruption has appeared as a roseola about twenty days since, and about a week thereafter, a very marked desquamation occurred, almost severe enough to suggest psoriasis. Great pruritus supervened and is now occasionally present. Examination shows marked adenopathy, of inguinal, axillary, pectoral, and cervical glands. The patient gives no history of specific infection, nor of any other accident which might have a bearing upon the case. Careful examination shows no signs or remains of an infecting sore anywhere. There has been and still remains on all the sites of eruption pigmentation, which, however, is not marked in character.

DR. MORROW presented, on behalf of Dr. Fox, a case of

PEMPHIGUS,

or a bullous affection closely resembling it.

J. H., æt. 24; plumber; was in fair health until a year ago, when he began to suffer from "cramps in stomach," and his digestion has since been greatly impaired.

Six weeks ago, an eruption suddenly appeared on lower extremities, and a week later on arms. It was red, itchy, and elevated, and gradually assumed a dull or bluish hue.

Two weeks ago he had rigors and fever; left his work, and within past week

the bullæ have appeared, varying in size from a pea to a hen's egg, and for the most part seated upon the sound skin with no inflammatory areola whatever.

The patient appeared weak and ill. Upon removing clothing, large tense bullæ and small vesicles were found here and there upon the extremities, trunk, and neck. The face was entirely free, but quite large bullæ, without surrounding inflammation of the skin, were discovered upon the hands. Two weeks ago, just before the bullæ appeared, he had begun wearing new red flannel under-clothing. Local poisoning from the dye in the flannel was suggested as a cause of the peculiar eruption of bullæ; these, however, were found on parts not touched by the flannel.

The discussion of these cases was postponed, owing to the time required for the *special order of the evening*:

THE DISCUSSION OF THE VALUE OF ARSENIC IN SKIN DISEASES.

DR. PIFFARD said he considered arsenic a drug of great value, but the more localized the eruption for which it is employed the less will be the benefit derived.

In subacute forms of eczema, full doses must be given until the physiological effect is produced, and the dose then kept up to the limit of toleration.

In acute eczema, that dose would probably aggravate the condition, but if reduced to one-tenth or one-twentieth the ordinary dose, a useful effect will be produced. Like some other drugs, the effect of a large dose is decidedly the opposite of a small one. Thus, ipecac in large dose causes emesis, and in minute quantities represses it; opium in small dose excites, in large stupefies. Hence, Sydenham said of the drug *opium, sedat*; but Brown, from his experience, was led to reply, *non sedat sed excitat*.

In acute eczema, a small dose of arsenic has a sedative curative effect, a large dose acts as a stimulant.

A small dose of ipecac is a stomach tonic; a small dose of arsenic is a skin tonic, a large dose an excitant. In practice he rarely prescribes a medium dose of the drug, it is either a large or a small one. He uses it constantly in chronic psoriasis of long standing, in cases where there is not much infiltration, but much epithelial hyperplasia. He cited a case of acute poisoning in the person of a patient with psoriasis, who accidentally took a drachm of Fowler's solution. The psoriasis vanished entirely within a few days. He has found arsenic of great utility in pemphigus. The changes after its use are too marked to cause any hesitancy in attributing the effect to the drug. The Germans deny its beneficial effect. It is probably useful in some of the other herpetic or large vesicular eruptions.

He cited a case of vesicular syphilide, about the diagnosis of which there was no question, and in which mercury and the iodide of potassium did not control the condition at all. Arsenic without any anti-syphilitic treatment was given a trial, and still there was no amelioration. A combination of the two was tried, and the vesicular formation was checked in a short time.

Arsenic is mentioned by one of the older writers as valuable in syphilis.

These diseases and acne are about the only ones in which it acts at all specifically. In cases having gastric and nervous debility, irrespective of the skin lesions, arsenic in small doses does good by bringing the system into a better condition by its tonic effect. Like other metals, such as iron, manganese, antimony, it is tonic in small doses.

DR. SHERWELL said: The limited amount of time allowed each member prevents me from considering Dr. Fox's propositions "*seriatim*." To generalize, however, I must strongly object to their general inference, which seems to deny the usefulness and what, in my opinion, is the extreme therapeutic influence of the drug *arsenic*.

The propositions themselves are somewhat vulpine in character, and some of them, and nearly all in fact, may be agreed to in part; but I must protest against at least their possible tendency to reflect upon the expert. I think certainly here the doctor's "*zeal for his house hath eaten him up*," and that his remarks are in

greatest measure intended for the general practitioner, and that not a good one; who, influenced by Hunt and his teachings, has followed that short cut to dermatology by the use of arsenical preparations in all cases and in all conditions. This is a fact which we are unfortunately often called on to deplore and correct, but the same rule applies, and in same degree, with mercury, quinine, opium, the iodides and bromides of potash, etc.

The doctor, it strikes me, is unhappy in the parallel he draws between it (arsenic) use and venesection, because I do not believe, as he seems to do, that this latter measure is useless, or at least not often indicated, abused, we all know it was, and has been.

I have availed myself of this means for rapid depletion on several occasions, when practising more generally than I now do, in cases of puerperal convulsions and the like, and have been well satisfied by results.

Ordinarily, depletion is now carried on by other means, as hyper-catharsis, etc., by hypodermic and other measures, so that nearly as quick results are attained by serous discharges, having absolutely the same, perhaps better, therapeutic effect; but still in the same direction. Depletion is now employed in very many inflammatory and other diseases, much as it has ever been.

As to the more or less specific action of arsenic in diseases having their seat or chief manifestation in the epiderm I am quite convinced. Every reason there is to believe that in neuroses of skin, and other affections of the same, having a malarial basis, it is equally effective. In that great archetype of squamous affections, psoriasis, I am positive, from actual experience, that its virtues are at least unexcelled by any one drug. I have used it alone sufficiently often for a fair test, and, although generally using adjuvant local applications in these cases, and often other medicaments of diuretic character, should feel lost without its aid.

Since the September meeting of the Society, I have had in my practice, private and clinical, beside old and relapsed cases, only two fresh cases of psoriasis, in both of which I have not felt justified in using arsenic alone; but all means, local and other, to produce speediest effect.

My colleague, Dr. Winfield, at Long Island Hospital Dispensary, has been more fortunate, however, and has had three cases: 1st, girl, æt. 9; 2d, male, æt. 45; 3d, adult male, age not given. By my direction and advice, he treated these cases with Fowler's solution alone. Result: No. 1. Child entirely relieved in fifteen days; No. 2. This second case, which was referred to me before treatment commenced, and which I have seen once since, exhibited the most extensive generalized eruption of a frank psoriasis I have ever seen, say three-fourths of the body and limbs affected; in somewhat less than three weeks, about seventy-five per cent improvement. The third case, time of treatment about three weeks, is approximately well. These somewhat remarkable and fortunate results were attained by gradually increasing doses of Fowler's solution from ℥iij. to ℥x. t. i. d., nothing else used or applied, not even simple unguent.

To sum up, while I do not claim arsenic as an absolute specific in all, or any one skin disease—in fact I doubt if such a thing as an absolute specific exists in medicine, I do believe that, in casting it aside or making light of it as advised, we should be doing away with what, with proper care, is the most powerful stimulant and therapeutic agent we possess.

DR. ALEXANDER said that his experience corresponded with that of Dr. Piffard. In chronic eczema and in psoriasis, arsenic was of decided benefit, and in acne was occasionally beneficial.

DR. MORROW said it had occurred to him that the results of the experience of a large number of physicians throughout the country, both specialists and general practitioners, would be of interest to the Society. In July last, through the pages of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES and other medical journals, he had requested information from physicians in relation to the general practice of employing arsenic in skin diseases, its superior value to other remedies in this class of affections, its ill effects, the preparation of the drug preferred, the doses employed, etc. In response to these inquiries he had received about seventy communications. The information contained in many of them was so meagre and indefinite as to be practically valueless. Many of the correspondents were non-committal, or expressed themselves in such general terms that their real opinions upon the points specified were largely conjectural. A tabulated statement containing an analysis of about forty of these letters in which the answers were for

the most part categorical, and contained definitely expressed views, based upon personal experience, was then read.¹

Continuing, Dr. Morrow said that, as far as his personal experience was concerned, he had formerly used arsenic quite extensively in the treatment of certain forms of skin disease, but during the past few years he had employed it on a constantly decreasing scale of frequency. Formerly he was accustomed to prescribe it in almost every case of psoriasis, but of late years he had practically abandoned its use, save in exceptional cases, with the full assurance that he could cause the eruption to disappear much more rapidly and completely under the influence of local treatment. He had also lost faith in the efficacy of arsenic as a preventive measure. A large experience had convinced him that the drug did not exercise a positive influence in preventing a subsequent recurrence of the eruption.

He had used it in certain forms of chronic eczema, and in some cases with benefit, but, after all, he thought it probable that equally good results would have been obtained from the use of alkalies, cholagogues, and other measures calculated to correct the constitutional vice of which the skin disease was the local expression.

In a number of cases of pemphigus he had used it with advantage. He recalled a case of constantly recurring pemphigus he had presented to the Society, a few years ago, in which the administration of arsenic was followed by a most brilliant result. In one case of dermatitis herpetiformis, there was a marked improvement in all the eruptive features from the use of arsenic. He considered an annular configuration of a vesicular eruption a very good indication for the employment of this drug, but as a rule the indications for the use of arsenic should be drawn from the general condition of the patient. He protested against the practice of administering arsenic in all chronic skin affections, irrespective of constitutional conditions. It should not be given in psoriasis or eczema simply because the patient has these diseases and arsenic has been empirically recommended for their cure.

The true principles which should guide us in the therapeutic employment of this drug are, to give it in cases in which the general condition of the system seem to require this remedy, and in correcting the abnormal systemic condition, the cutaneous symptoms are correspondingly improved.

He was in the habit of giving arsenic in skin diseases in which a chronic malarial element was present, experience having shown that such cases are more amenable to the influence of arsenic than of quinine.

Advantage is also derived from the use of arsenic in certain forms of chronic erythema, acne, and rosacea, associated with a congested and catarrhal condition of the stomach. He was led to employ it in this class of cases from his observation of the remarkably good results obtained from small doses of Fowler's solution in the alcohol stomach. In correcting the morbid condition of the stomach, the coincident skin troubles speedily vanish. Arsenic possesses undoubted virtues as a neuro-tonic, and is applicable in all forms of skin disease associated with a lowered or impaired condition of cutaneous innervation.

Dr. KEYES said he had little to add to the views he had already expressed before the Society, and embodied in a recently published paper in the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES. He indorsed the views of Dr. Piffard and most of what Dr. Morrow had said, especially regarding the principle that the patient should be treated rather than the disease; he thought it a point worthy of being more insisted upon. Certain it is that some stomachs will not tolerate arsenic. The speaker had recently seen a case which, theoretically, should have yielded to arsenic, but did not, although the drug was pushed until the patient had been poisoned by it, and had lost eighteen pounds in six months' time. Coming under his care, he had stopped all drugs, and cut off the patient's tobacco and whiskey until his constitution was built up, when the eruption yielded to treatment. This procedure applies equally well to other drugs. Treat the patient as a whole, not relying upon the drug alone to do the work. One case of pemphigus, the speaker remembered, occurring in a lady of 60 years, and quite extensive, had yielded promptly to arsenic. A prolonged course of arsenic in small doses, when the stomach is in a suitable condition, does good in herpes, especially in recurrent herpes preputialis. He has found a little arsenic combined with mixed treatment

¹ See page 374.

beneficial in syphilis; noticeably in the erythemato-papular and late secondary lesions. It also has a good influence in controlling the irritating cutaneous effects of the iodides. One or two drops of Fowler's with the iodide of potassium or sodium will often moderate the amount of iodic acne on the face, and assist in the digestion of the iodide. He does not know that it interferes with the effect of the mixed treatment. Guéneau de Mussy had called attention to the arsenite of soda as found in the water of the Bourboule Springs. De Mussy used it in the form of baths for fibrous phthisis and other diseases, as well as internally, and he believed with good results. The speaker now used arsenite of soda in preference to any other form of the drug, giving it in dose of from $\frac{1}{10}$ to $\frac{1}{2}$ grains— $\frac{1}{10}$ gr. being a fair dose. It is given in solution in water. It is combined with mixed treatment, and children take it readily. In conclusion, he thinks that arsenic is frequently exceedingly useful when the individual as well as the disease is studied, and the drug is not used in a routine way.

DR. ALEXANDER had used the Bourboule water, and found that it converted acute moist eczema into the dry form, especially in children, but that its value was limited. He gave usually half a wineglassful as a dose to a child.

DR. LEWIS had used arsenic in chronic eczema, especially in the infantile variety. He had carried out the suggestion made by Stephen Rogers many years ago, of commencing with a small dose and increasing rapidly until as much as fifteen drops of Fowler's was given to a child a year old. This is a larger dose than is usually given. He uses also the arseniate of iron in $\frac{1}{8}$ -grain doses in uterine, malarial, and other diseases. As regards the local use of arsenic, he had employed it as a caustic in about one hundred and fifty cases of surface epithelioma, and is as strongly as ever in favor of it, and has on several occasions defended it as a caustic against the assertions of surgeons that it is a local irritant producing sloughing. Its action is rapid, circumscribed, and can be controlled and followed. It is, in his opinion, the best caustic which exists for surface epitheliomata which are not too large. He prepares Marsden's paste with two parts of arsenic and one of acacia, mixed up with a few drops of water. Marsden's rule, not to apply it to a surface of more than four square inches, is a safe one to follow. He has treated larger surfaces, but never over a square inch at a time. It may be applied in a thickness of nearly an eighth of an inch. The surrounding skin is protected with cotton, stuck fast to the paste. It is left on from twenty-four to seventy-two hours, and a poultice is then applied. It does not usually cause great pain. *He had never had a case of poisoning from its use in this way, but there are almost always constitutional symptoms.* He saw a decided paralysis in one case from its application to a cancer of the breast—a form for which, in his opinion, arsenic paste should never be employed. The absorbents are too active in cancer of the breast.

DR. STURGIS said the arseniate of iron in $\frac{1}{10}$ grain doses he had found good in chronic psoriasis, in desquamating syphilides, especially of the palms, in urethral neuralgias, and irritable urethra generally. In squamous syphilides the preparations of arsenic come especially into play. He has found Donovan's solution an extremely good preparation, and agrees fully with the gentlemen who had spoken in favor of the combination of arsenic and mercury in the treatment of syphilis.

DR. MAYNARD, of Chicago, an invited guest of the Society, spoke of the abuses largely seen from the indiscriminate use of the drug. He has thought arsenic not indicated in acute disease, but has found it of much value in the more chronic scaly formations and, in one case in particular, of urticaria pigmentosa in a young child, its use was followed by very brilliant results. The child who had had the disease from the age of two months till it was a year old, was entirely cured and remains well. As to its external use, he has employed it in a large number of cases and regards it as the best caustic in the materia medica. He has applied it to some fifty cases of lupus, superficial epithelioma, and erythematous lupus and has never yet seen any evidences of poisoning.

DR. ALLEN said that the opinion which he had expressed at a former meeting of the Society, that arsenic was largely used in a routine way for all classes of skin diseases by many practitioners, distressing as the proposition was, he must reiterate, as being the result of his observation and statements made to him by practitioners. The first rule of therapeutics should be *to do no harm*. That arsenic is a potent drug capable of doing much injury when carelessly adminis-

tered none will gainsay. When improperly given, arsenic does harm, 1st, by not doing any good; 2d, by producing inflammatory conditions, other eruptions, intensifying at times existing pigmentary deposits in the skin, and producing them at other times *de novo*, and by producing toxic symptoms. To be of benefit the drug must be pushed in suitable cases to the point of toleration. In thus increasing the dose, great danger is incurred of producing symptoms of constitutional poisoning. In the experience of the speaker, a course of treatment must often be interrupted on account of the physiological effect of the drug. The tolerance acquired by Styrian and other arsenic eaters does not appear to exist for all people. In psoriasis he had occasionally seen good results from arsenic, but they were usually of a more or less temporary nature. The time to use arsenic in this disease he believed to be after the eruption had been removed by local treatment, or as it is on the decline, and the drug must be continued long in the interval of freedom from eruption. The Asiatic pill is the form he prefers for administration, and given in gradually increasing dose. He also uses at times the liq. potassii arsenitis, and the liq. sodii arseniatis, and often gives them in Vichy or cinnamon water before instead of after eating, a mode of administration he had learned from Dr. Bulkley, and had found, he thinks, to act more quickly and has not seen any bad effects on the stomach from it. He believed that the use of arsenic in acne was a common practice, but he had never seen much good result from it in this disease, except in a few cases in which the papules were small and few comedones present. In one case of lichen ruber in a young lady, the effect of arsenic appeared almost magical. The abuse of the drug in treatment is not confined to its internal administration. Arsenical pastes, which form excellent caustics when properly used, are much employed by irregular practitioners for the removal of morbid growths, tumors, etc., and not infrequently the most unfortunate results follow. A lady upon whom he operated for a lipoma of the thigh some months since had fallen into the hands of one of these Philistines, who had applied a paste in such a manner to the tumor to "draw it out by the roots" that in a few days the lady was taken violently ill, had an anxious expression, was very restless, had frequent vomiting, abdominal pain, frequent dysenteric stools, intense thirst, and a marked urticarial eruption quite generally diffused over the body. At the point of application of the plaster the skin was intensely inflamed, and several superficial sloughs formed. For several days she was quite ill, and did not wholly recover from the effects of her experience for several weeks. To use arsenic for its caustic effect externally, it must be applied in a concentrated form to destroy the absorbent properties of the skin so quickly that no constitutional effects follow. He had had several cases of arsenical dermatitis attended with slight constitutional symptoms although the lesions were extensive. Two cases occurred in longshoremen, the feet and legs being first affected, he was enabled to establish the fact that they had been unloading dry hides which are cured with arsenic. The arsenical dust had sifted through their clothing and low shoes producing bullæ, large vesicles, etc., followed by ulceration and swelling of the feet, legs, and hands. Papules and erythematous patches were scattered over the legs and thighs, attended with burning, itching, etc., etc. The speaker could not agree with Dr. Lewis that the pain from Marsden's paste was not usually severe. In his experience patients suffered intensely after its application.

DR. PIFFARD said the preparations almost invariably employed by him are the acid, combined with red or black pepper, as in the Asiatic pill. He had devised a powder combined with pepper which he called Asiatic powder, and had used extensively. All the peppers are of service in malaria, over which arsenic also has an influence. The old formula for the Asiatic pill, mentioned by the last speaker, included a drug called *muar* or *Calotropis gigantea*, and he had had it prepared at times in this way. Fowler's solution he considered the least desirable form, and had never seen any advantage from the arseniates of iron, quinine, strychnine, etc. When these drugs are called for together, he gives arsenious acid and iron or quinine or strychnine, as the case might be, mixed with the arsenic, and not in chemical combination. He had advised the hypodermic use of arsenic in the neighborhood of localized lesions or diseased patches themselves when they were not too numerous, as the arsenic seemed to exert a more decided influence when thus locally used. This method of administration had been suggested by himself and a German observer at about the same time.

In epithelioma, he had made use of paste of his own, which he preferred to

Marsden's. He prepared it with equal parts of chloride of zinc and chloride of chromium, and enough arsenic to make a paste. He had found arsenical pastes to produce great pain which persists and causes severe suffering, great inflammatory reaction and swelling, more than other caustics. In contrast, the actual cautery produces the least, the hotter the better.

DR. MORROW said, in regard to the hypodermic use of the drug, that several of the correspondents who had answered his questions had given it up on account of the severe pain occasioned. Dr. Piffard answered that they had given too strong a dose.

Dr. Morrow did not wholly agree in regard to arsenic seeking out morbid tissues. The same selective action for diseased tissues had been claimed for lactic acid and other caustics, but careful experimentation had disproved such claims.

DR. PIFFARD said he had referred more especially to epitheliomatous growths.

DR. SHERWELL related a case of multiple sarcoma, which he had cured with Donovan's solution.

DR. LEWIS said that the pain from arsenical paste depended upon the location of the disease to which they were applied.

DR. TAYLOR's remarks on closing the discussion are elsewhere published (see page 362).

Correspondence.

ARSENIC IN SKIN DISEASES.

To the Editor of the Journal of Cutaneous and Venereal Diseases.

DEAR SIR:—Having had considerable experience in the use of arsenic in skin diseases, and seeing the request in medical journals to physicians for answers to certain questions, I write my ideas as briefly as possible and hope they may be of some benefit.

First Question. No, I am not in the habit of prescribing arsenic "*generally*" in skin diseases; I formerly so treated my cases. I supposed the drug applied to many or nearly all skin diseases. As long as I followed this blind, theoretical idea, I had poor success in the treatment of cutaneous disorders. I certainly think that our text-books do not make sufficient distinction between those cutaneous diseases benefited by arsenical treatment and those which are not. Medical lectures are open to the same general objection.

Second Question. I have found arsenic the most beneficial in those cases of skin diseases in which there appeared to be a depraved condition of the blood or anæmia; in those cases where there existed evident cachexia, and where the skin appeared white and bloodless; diseases that leave the skin dry and scaly, with a surface which, when rubbed with the hand, sheds a bran-like scale. Thousands of practitioners call nearly every case of skin disease eczema, and prescribe Fowler's solution. This is not intelligent medical practice.

Third Question. I have often seen every symptom of the disease aggravated by the exhibition of arsenical preparations, notably those cases where there was plethora or a full habit associated with the disease. Where there are inflammatory symptoms, and the skin is red and capillaries congested, arsenic should not be given. In most diseases I do not pay much attention to symptoms, but try to find the cause of the disease, but in skin diseases I am governed very much by the symptoms—objective symptoms, in regard to what I prescribe.

Fourth Question. I generally prescribe the liquor potassæ arsenitis in skin diseases, because it affects the system quickly; but there are cases in which the sulph. arsenic either in solution or pill form, does better. In many cases benefited by arsenic the good results are secondary. The drug acts as an alterative

and tonic, improving the appetite, raising the nutrition, and of course indirectly acting upon the skin as the condition of the blood improves. Doses cannot be given, for every case shows a susceptibility of its own to the drug. I give it in sufficient doses to obtain the constitutional effects, and then lessen the dose a little and continue the drug, sometimes stopping it, and after a little giving again. I think external applications are not used enough or given sufficient attention.

Truly yours,

A. E. FARNHAM, M.D.

EAST MADISON, MAINE.

To the Editor of Journal of Cutaneous and Venereal Diseases.

DEAR SIR:—To a request in your editorial on "Arsenic in Skin Diseases" in JOURNAL OF CUTANEOUS AND VENEREAL DISEASES of July, 1886, I take pleasure in furnishing information upon the points mentioned, according to my own personal experience with the drug.

1. *Are you in the habit of employing arsenic generally in the treatment of diseases of the skin?*

No.

2. *In what forms of skin disease have you found arsenic of superior value to other remedies?*

In psoriasis; squamous eczema; in several cases of chronic acne, associated with gastric irritation; in some cases of chronic intermittent urticaria, in which other remedies used had failed; in several cases of persistent furuncular eruption coming out in successive crops.

3. *What ill effects have you observed from its use?*

Intense itching all over the body in a few cases, coming on principally when the patients get into bed, with dryness of the skin and furfuraceous desquamation about the legs and chest.

Herpes preputialis in one case, which always made its appearance after giving arsenic for a few days, minim doses of liq. arsenicalis (Fowler's solution) or liq. arsenici hydrochlorici B. P., producing it almost as rapidly as five-minim doses of either of the above preparations given three times a day.

A papular eruption about the face in one case, attended with a decided amount of pruritus; the papules, varied in size from a pin point to No. 4 shot, were discrete, and were more or less scaly upon their summit. The eruption disappeared after a few days, upon the discontinuance of the drug, and was followed by furfuraceous desquamation of the part affected.

4. *What preparation of arsenic do you prefer, and in what doses do you employ it?*

I generally employ Fowler's solution in one to five minim doses, or liq. arsenici hydrochlorici B. P. in one to five minim doses.

In one minim dose, I generally give it three times a day *just before meals*.

In five minim doses, *directly after meals*.

I frequently combine the liq. arsenici hydrochlorici with tinct. ferr. perchloridi, acid. phosphorici (dil. with glycerin and water), and Fowler's solution, with tinct. nucis vomicæ or liq. strychniæ, in suitable doses.

R. L. FAITHFULL, M.D., L.R.C.P.

43 PHILLIP STREET, SYDNEY, Sept. 7, 1886.

Editor of Journal of Cutaneous and Venereal Diseases.

DEAR SIR:—In response to your request, in the *Medical Record*, regarding the use of arsenic in skin diseases, I would say that I fully coincide with the views expressed by Dr. G. H. Fox in his recent article on the subject (*N. Y. Medica*

Monthly, No. 1). I, too, repudiate the routine practice of indiscriminately administering arsenic against diseases of the skin, as frequently done, even without proper diagnosis.

Being a pupil of Kaposi, and a strong adherent to the Vienna school, I always relied more upon the topical treatment, and only gave arsenic as an *adjuvant* wherever I believed it beneficial. Therefore, from my own experience I could not ascertain how much of the result was due to the arsenic alone.

Cases of lichen ruber, in which I would rely upon it principally, have so far not come under my observation in America, and I can judge about the excellent result against that disease only from my experience in Kaposi's service. In cases of psoriasis, I regularly prescribe it, fully confident of its effect, but even there never without contemporaneous external treatment (chrysarobin, pyrogallie acid, etc.); this is but natural in private practice, where a speedy result is desired. Besides, I sometimes gave it in cases of very chronic (dry) eczema, of pruritus, chronic urticaria, in a case of impetigo herpetiformis (Hebra), without, however, observing any *decided* beneficial result from its use.

In regard to its ill effects, I would say that I usually instruct my patients as to its possible bad influence, and have discontinued its use, or at least diminished the dose, whenever I noticed disturbances on part of the digestive organs, the conjunctivæ, etc. Only on a child, 5 years of age, which had taken Asiatic pills but a short time, decided poisonous effects (cramps, unconsciousness) were observed but soon disappeared after discontinuance of the drug.

As to the form in which I give it, I had, from my Vienna experience, a good deal of confidence in the so-called Asiatic pills; but, although I prescribed them in a smaller dose than given in the usual formula (from 0.25 to 0.50 ad pil. No. 100), I usually had to stop their use, on account of the bad effect on the stomach. Subcutaneous injections of Fowler's solution (4.00 ad 20.00 aq. dest. $\frac{1}{2}$ to 1 Pravaz' syringe) were almost invariably followed by considerable local pains for many hours, even though all possible precautions had been observed; for this reason, I could not use them to any great extent.

Fowler's solution with aq. menthæ pip. (ãã) was always very well taken. Beginning with four drops of this mixture three times daily after meals, I usually could increase up to twenty drops (three times daily) without seeing any ill effect, afterwards decreasing again, and so on.

CHICAGO, ILL.

JOSEPH ZEISLER, M.D.

Editor of the Journal of Cutaneous and Venereal Diseases.

DEAR SIR:—In the July number of the *West. Med. Reporter*, page 272, will be found under the head of "The Useless Administration of Arsenic in Skin Diseases," most of my views on arsenic in skin disease; I offer this as answer to your interrogatories. I have no very decided ideas as to its *injurious* effects, however, but know that its continued use in increasing doses is fraught with danger to the constitution in general, and likewise locally to the digestive apparatus, the chief source of existence and health. While we all seem obliged at times to use remedies empirically, I am opposed on general principles to the indiscriminate, empirical, unscientific, and reckless use of any rank poison, more especially one of which I know no *positive* good. I may say still further, that I think I have seen erythematous conditions aggravated or produced by its internal use.

Most respectfully, etc.,

HENRY J. REYNOLDS,

Prof. Dermatol., College of Physicians and Surgeons, Chicago, Ill.

CHICAGO, ILL.

THE VALUE OF ARSE-

	1.	2.
Klotz, Herman E., New York.	No	Alopecia simplex and areata, atrophy of nails, lichen ruber, lupus erythematosus, psoriasis, eczemas quamosum (simultaneous application of external remedies).
Norton, H. G., Imlaytown, N. J.	Yes	Eczema and psoriasis.....
Young, E. G., Hazelton, Iowa.	Yes, generally..	In the different forms of eczema, most valuable drug in m. m. in all non syphilitic skin diseases.
Wessinger, J. A., Howell, Mich.	Habitually in certain forms of skin disease	Chronic and papular and squamous eczema, inflammatory condition accompanying chronic indolent ulcer of leg.
Chenery, Elisha, Boston, Mass.	Sheet anchor in limited range of skin diseases.	Psoriasis, other forms of skin disease in which the tonic effects of arsenic are called for; nearly a specific for any chronic eruption.
Bradbury, O. N., South Paris, Maine.	Yes	Eczema and those of kindred nature....
Brodnax, Benj. H., Brodnax, La.	In <i>all scaly diseases</i> .	Pityriasis capitis, eczema, lichen agrius, one or two forms of urticaria.
Chace, H. P., Highland Falls, N. Y.	Generally in eczema.	In late years, not at all, believing it utterly inefficient; best remedy we have in psoriasis.
Ross, W. S., Madisonville, Ky.	Yes	All chronic affections of the skin.....
Daniel, F. E., Austin, Texas.	No.....	In no diseases found arsenic of superior value; used it with success in some cases of eczema where arsenic was indicated as a tonic; abused and overrated remedy.
Woodbury, F., Philadelphia, Pa.	Rarely use it....	In chronic skin diseases in which itching is not marked.
Ohmann-Dumesnil, A. H., St. Louis, Mo.	No	In chronic squamous and tubercular diseases, valuable in skin affections depending upon neurotic troubles.
Putnam, F. W., Binghamton, N. Y.	No	Boils.....
Borcheim, L. I., Atlanta, Ga.	Yes	Chronic eczema, especially in children; all scaly eruptions.
Eastwood, W. F., Claremont, Ont., Ca.	Yes; generally..	Chronia eczemas; boils, acne, psoriasis, chronic urticaria.
Jernigan, Chas. H., Enon, Ala.	Yes	All chronic cutaneous trouble.....
Getter, J. P., Allonsville, Pa.	Formerly, yes; recently have lost faith in drug.	Chronic eczema; furunculosis.....
Rosenberry, H. L., Miltonsburgh, Ohio.	No	Eczema, lichen, crusta lactea.....

Columns numbered 1 to 4, in answer to the following questions:

1. Are you in the habit of employing arsenic generally in the treatment of skin diseases?

2. In what diseases of the skin have you found arsenic of superior value to other remedies?

NIC IN SKIN DISEASES.

3.	4.
Loss of appetite, dyspepsia, and similar disturbances of the digestive organs.	Fowler's sol. (gtts. vi. t. i. d. in German tincture of ferri pomati). Asiatic pills, 1 to 2 per diem.
None; sometimes too large doses temporarily aggravate eczema.	Fowler's sol. (gtts. i. to x.).
Temporary gastric and intestinal irritation.	Fowler's sol. (gtts. ij. and increase) in combination with a diuretic.
Conjunctivitis; in some cases, even from very minute doses.	Fowler's sol. (minimum dose, increased to maximum until full physiological effect, then reduce to minimum, and increase as before).
Untoward ill effects on eyes.....	Fowler's sol. (beginning 10 drops, 4 to 6 times a day, come down to 3 to 6 drops if ill-effects appear).
Nausea	Fowler's sol. (5 to 10 drops 3 times a day, and increase).
Of 197 cases, in 2% a rubeolous rash; in 20% puffiness of the face and dryness of the fauces.	Fowler's sol. (1 to 5 drops, increased 6 to 15 drops, increasing and decreasing, according to constitutional effects produced).
Intolerance by the stomach and trouble under the eyes.	Fowler's sol. (5 drops after meals, gradually increasing to 10 or 12). No bad effects from its long continuance when dose is carefully regulated.
None	Fowler's sol. (gtts. v. to vij. t. i. d.). If I suspect syphilitic disease, I give Donovan's sol.; same doses.
No ill effects.....	Fowler's sol., 5 drops, increased to 10.
None.....	Fowler's sol., small doses; arseniate of sodium, $\frac{1}{2}$ gr. combined with hydrochlorate of quinine; also Donovan's sol.
None	Fowler's sol., 3-drop doses with wine of iron; arsenious acid $\frac{1}{60}$ gr.; bromide of arsenic.
None.....	Fowler's sol., gtts. i.-v. t. i. d., after meals.
None.....	Fowler's solution.
Irritable stomach and headache..	Fowler's sol., gtts. iiij.-v.; Donovan's sol., $\text{m}\times$. doses.
None from judicious use.....	Fowler's sol.; under certain conditions, prefer Donovan's.
.....
Nausea and oedema of the face..	Fowler's sol., 10 drops t. i. d., after meals.

3. What ill effects, if any, have you observed from its use?

4. What preparations of the drug do you prefer, and in what doses do you employ it?

THE VALUE OF ARSENIC

	1.	2.
Dennis, E. J., Bavaria, Kansas.	Yes	Urticaria, lichen strophulus, prurigo, impetigo, ecthyma, herpes, pemphigus, scabies, ambustio, gelatio, and various syphilodermata.
Browen, George J., Coovelo, Cal.	Almost universally.	Eczema and psoriasis.....
Marseau, L. T., Napierville, Can.	Yes, in all chronic skin diseases.	Eczema.....
Miles, George W., Oneida, N. Y.	Not only <i>generally</i> , but <i>invariably</i> in every case.	I cannot compare it with other drugs, as I never use anything but arsenic.
Halley, George, Kansas City, Mo.	Generally	In all cases where there is exudation, with infiltration into the cutis vera.
Le Hardy, J. C., Savannah, Ga.	Generally.....	Indispensable in chronic cutaneous diseases, and in eczema, herpes, etc., occurring in the course of syphilis.
Russell, C. P., Utica, N. Y.	Restricted to psoriasis, chronic squamous eczema, acne, and pemphigus.	In psoriasis, more especially the discrete forms.
Brown, J. S., New Market, Mo.	Invariably in chronic cutaneous disease non-syphilitic.	Never give other remedies, except in combination with arsenic.
Berry, J. J., Portsmouth, N. H.	Generally	In chronic forms of eczema, psoriasis, herpes zoster, acute or chronic.
Crawcaur, I. L., New Orleans, La.	Largely	Chronic eczema and psoriasis.....
Beach, Wooster, New York City, N. Y.	No.....	In chronic eczema; have little faith in arsenic.
Cross, Theodore P., Sun Prairie, Wis.	Yes.....	All diseases depending upon impaired condition of the blood.
Brush, R. H., Grand Eddy, Mo.	Extensively....	In eczema, especially in infants, and psoriasis, has specific action.
Ensign, H. D., Boone, Iowa.	Yes.....	Anæmias and morbid conditions of cutaneous glands; exudations.
Jewell, P. M., Ossian, Iowa.	Yes... ..	Most forms of eczema
Beville, C., Winfield, Kansas.	Yes.....	All forms of eczema, lichen ruber, acne, purpura, vitiligo, all scaly diseases.
Free, Spencer M., Baltimore, Md.	No.. ..	Psoriasis.....
Pearson, Benj., Slippery Rock, Pa.	Yes.....	In eczema it is the sheet anchor.....
Strickler, O. C., New Ulm, Minn.	Generally.....	In all chronic stages of skin diseases....
Allen, H. C., Ann Arbor, Mich.	No.....	In those indicated by the similarity of the symptoms.
Campbell, E. N., Good Hope, Ill.	Yes.....	Acute and chronic eczema.....
Moore, W. G., St. Louis, Mo.	No.....	Chronic squamous diseases, as psoriasis, squamous eczema, etc.

IN SKIN DISEASES—*Continued.*

3.	4
.....	Arsenite of potash, arseniate of soda, arseniate of ammonia, arseniate of quinine, De Valangan's sol., and Donovan's sol., 5 drops Fowler's sol., or $\frac{1}{8}$ grain of arsenious acid.
Impairment of appetite	Fowler's and Donovan's solutions in minimum doses long continued.
Conjunctivitis, vomiting, and diarrhoea.	Fowler's sol., 1 to 3 drops after each meal.
Severe symptoms of arsenical poisoning.	Fowler's solution, 3 to 5 drops.
None	Sol. sodii arseniatis; begin with small dose, increase rapidly until I get toxic symptoms, then revert to small dose ($\frac{1}{16}$ – $\frac{1}{8}$ gr.).
Burning sensation in the stomach and urticaria.	Arseniate of potash and iodide of arsenic in small doses, long continued.
Erythematous eruption.....	Arsenious acid ($\frac{1}{80}$ gr.) in pill form is combined with iron and strychnia.
Occasional puffiness of the face..	Fowler's solution, 3 to 10 drops t. i. d. after meals.
Temporary toxic effects.....	Fowler's solution, 2 to 8 drops after meals; occasionally Donovan's solution.
None	Arsenious acid, $\frac{1}{160}$ to $\frac{1}{80}$ gr. 3 times daily until suffusion of the conjunctiva occurs, reverting to smaller dose.
.....	Fowler's solution, 5 to 8 drops 3 times a day.
None	Fowler's solution, 5 to 10 drop doses.
Only temporary ill effects.....	Fowler's solution, 5 drops t. i. d. after meals; occasionally De Valangan's and Donovan's solutions.
None	Fowler's solution, iv. to xv. or xx. drops.
None	Fowler's solution, 5 drops, increasing to limit of toleration, 12 to 15 drops, t. i. d.
None	Fowler's solution, 3 to 10 drops after each meal.
Nausea with anorexia, inflammation of the skin with fine eruption, and burning and itching in one case.	Fowler's solution.
Pain in stomach, and vomiting..	Fowler's solution, 1 to 6 drops.
Aggravates acute eczema.....	Fowler's solution, 5 to 8 drops.
None	Arsenious acid.
None	Fowler's solution, 2 to 5 drops in chronic cases; 4 to 10 drops in acute cases.
Gastric disturbances and occasional aggravations of acute eruptions.	Fowler's solution in doses of 5 to 15 drops.

Selection.

EXCISION OF THE INITIAL LESION OF SYPHILIS.

DR. ZAREWICZ reports fourteen cases of excision of the primary chancre. The operation was performed in 1 case forty-eight hours after the appearance of the lesion; in 4 cases from six to ten hours; in 2, after twelve hours' time; in 1, after fourteen hours, and in 2 cases after 21 and 22 days.

The results were not very encouraging, to be sure, as in every case constitutional symptoms of the disease made their appearance, but the following reasons are given by the author for carrying out and advising the procedure:

1. By excision, the chancre is done away with quicker than by any other method, and the cure of the lesion is thus advantageously shortened. It sometimes happens that the induration returns in the cicatrix, but after this method it disappears more quickly than when the chancre has been treated in any other way.

2. The excision appears to modify the secondary symptoms.

3. Finally, we cannot deny the observations published by many physicians, even unicists, that in many cases positive results have been obtained by excision.

It appears that frequently the syphilitic poison does not advance rapidly in a centripetal direction, and in such cases the hard sore remains for a long time a local affection, and its excision under these circumstances can prevent general infection.—*Deutsch. Med. Zeit.*, July 29, 1886.

Books and Journals Received.

Traité pratique et descriptif des Maladies de la Peau, par ALFRED HARDY, Professeur de clinique médicale à la Faculté de médecine de Paris, Médecin de l'hôpital de la Charité, etc. Paris, 1886. Librairie J. B. Baillière et Fils. 1 volume in 8° de 1,240 pages. Will be noticed in subsequent number.

The Pathology and Treatment of Syphilis and Allied Venereal Diseases, by HERMAN VON ZEISSL, M.D. Second edition. Revised by Maximilian von Zeissl, M.D. Translated with notes by H. Raphael, M.D. New York, D. Appleton & Co., 1866. Will be noticed in subsequent number.

An Abstract of Lectures on Lepa, by J. L. BIDENKAP, with numerous chromo-lithographic plates. Christiania: Huschy & Co, 1886.

Teoryja Wsteczego Zarazenia Sie Matki Przysmiotem od Plodu (Theorie "Choc en Retour"), by DR. KAROL SZADEK. Warszawa, 1886.

Leczenie Przysmiotu, by DR. KAROL SZADEK. Warszawa, 1886.

Das Ol. Santali Ostindie als Antiblennorrhagicum, von DR. LETZEL. Reprint (*Allg. Med. Zeitung*).

Cas d'une Atrophie Idiopathique de la Peau par ALEXIS POSPELON. Reprint (*Annales de D. et S.*, Sept. 25, 1886).

Neuroses of the Genito-Urinary System, by L. BOLTON BANGS. Reprint.

Is Electrolysis a Failure in the Treatment of Urethral Strictures? By ROBERT NEUMAN, M.D. Reprint.

Analysis of 383 Cases of Skin Diseases Treated at the Military Hospital of Kien, with Cases, by CHARLES SCHADECK. Reprint.

Ein Fall ausgedehnter Acne Vulgaris, Complicirt durch Entzündliche Papillome. von CARL SCHADECK. Reprint.

Sulla Terapeutica Moderna delle Malattie della Pelle, pel PROF. COMM. CASIMIRO MANASSEL. Rome, 1886.

Sifilide Ereditaria, Discorso Inaugurale, pel PROF. COMM. CASIMIRO MANASSEL. Rome, 1885.

Ueber ein neues Endoskop, von DR. JOS. SCHÜTZ. Reprint (*Munch. Med. Wochenschrift*, 1886).

Ueber Calomelinjection zur Syphilisbehandlung, von PROF. DR. A. NEISSER. Reprint. Breslau, 1886.

Ueber Therapie der Syphilis, von PROF. DR. A. NEISSER. Reprint. 1886.

Ueber die Ansteckungsfähigkeit der chronischen Gonorrhoe. Reprint. 1886.

Demonstration von Leprazellen in Hautschnitten (in Bindegewebsspalten, Blutgefässen, Schweissdrüsen u. s. w.), von HERR TONTON.

The Hygiene of the Hair, by G. T. JACKSON, M.D.. Reprint. 1886.

Das Mollin, ein neues Seifenpräparat als Vehikel für die kutane Anwendung dermatologischer Medikamente, von TH. ALFRED KIRSTEN, of Leipzig. Reprint. 1886.

Mittheilungen aus der Strassburger Klinik für Syphilis und Hautkrankheiten, von DR. A. WOLFF und DR. J. NEGA. Reprint. 1886.

Vergleichende Untersuchungen über die Resorption und Wirkung verschiedener zur cutanen Behandlung verwandter Quecksilberpräparate, von DR. JULIUS NEGA, Strassburg, 1886.

Ueber die Beziehungen zwischen Stäbchen und Coccen, von DR. ADOLPH LUTZ. Reprint.

Das Ichthyol bei inneren Krankheiten, von DR. P. G. UNNA. Reprint.

Ueber Dünndarmpillen, von DR. P. G. UNNA. Reprint.

Clinical History and Treatment of Lichen Rubra, by DR. P. G. UNNA. Reprint.

Item.

THE ASSOCIATION OF GENITO-URINARY SURGEONS.—In response to a circular letter from Dr. E. L. Keyes, addressed to a number of gentlemen in various parts of the United States interested in genito-urinary surgery and venereal diseases, the following gentlemen met at No. 1 Park avenue, Oct. 16, 1886. Drs. A. T. Cabot and F. B. Greenough, of Boston; Drs. E. L. Keyes, P. A. Morrow, and F. N. Otis, of New York; Dr. R. Park, of Buffalo; F. Rockwell, of Brooklyn, N. Y.; Drs. F. R. Sturgis and R. W. Taylor, of New York; and Dr. J. W. White, of Philadelphia. Telegrams and letters expressing regret at inability to attend were read from Drs. Brinton, Bryson, Garnett, Greenway, Gross, Hingston, Hyde, Masten, and others. Dr. Keyes was chosen temporary chair man, and Dr. Taylor, temporary secretary. The meeting then discussed the various matters incident to the formation of a scientific association. It was voted that a committee be appointed with power to draft a constitution and by-laws, and make arrangements for a future meeting. The Committee of Organization consists of the following gentlemen: Chairman, Dr. Keyes; Secretary, Dr. Taylor; Drs. Sturgis, C. M. Masten, A. T. Cabot, J. W. White, and J. N. Hyde.

Editorial.

THE JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

WITH the completion of the fourth volume of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, the title will be changed to that of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

This change is made with the view of broadening the scope of the Journal, so as to embrace the consideration of a large class of genito-urinary diseases of great interest to the general practitioner as well as to the specialist, which, because not strictly venereal, have been excluded from its pages. We feel assured that the introduction of this new feature will add very materially to the interest as well as the practical usefulness of the Journal.

The recent organization of the Association of Genito-Urinary Surgeons will doubtless give a fresh impetus to the study of genito-urinary diseases and syphilis in this country. We shall be pleased to bring before the profession the results of the work of this association in these special departments. We have already secured the promise of contributions from some of its leading representatives, and hope to secure the support of others.

The ever-increasing growth of our knowledge of the diseases to the consideration of which this Journal is specially devoted, renders it indispensable to every physician who wishes to keep up with the advances made in dermatological and genito-urinary practice. No effort will be spared to maintain the high character which the Journal has already achieved for scientific excellence and practical value. The wants of the general practitioner will be especially considered. The foreign correspondence from representative men, which has formed such a distinctive and valuable feature, will be continued with an enlarged corps of contributors.

With the beginning of the new volume, the size of the Journal will be increased by the addition of eight pages of reading matter. It will be still further enlarged should the demands upon our space render it necessary.

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